From:

To: HRA

05/09/2008 12:48

#226 P. 002/065

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2008 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A BUILDING		(X3) DATE SURVEY COMPLETED	
		09G037	B. WING	· · · · · · · · · · · · · · · · · · ·	04/0	4/2008	
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	rs	W 000			,	
	2, 2008 through Approcess was utilized clients was selected of seven males with disabilities. The surphyservations in the	vey was conducted from April ril 4 2008. The full survey d. A random sample of four diffrom a residential population mental retardation and other receipt findings were based on group home and at four day as and a review of records, incident reports.					
	revealed concerns-insafety of Client #1. determination was in jeopardy of Client #1. The facility's Qualific Professional (QMRI notified of the safety immediate jeopardy remained onsite unt serious and immediate plan that prohibited program until his median safety in the program until his median safety in the program until his median safety in the sa	made that an immediate 1's health and safety existed. ed Mental Retardation P) and House Manager were concerns regarding the at 5:28 PM. The surveyors if the facility addressed the ate jeopardy by initiating a Client #1's return to the day ealtime service at the program e support was designed to			P- NW MAY -9	RESERVE.	
	failure to be in comp Participation in Gove Protection.	survey resulted in the facility's liance with the Conditions of erning Body and Client			2: 0b	SECTION AND ADDRESS OF THE PARTY OF THE PART	
W 102	483.410 GOVERNIN MANAGEMENT	IG BODY AND	W 102				
	The facility must ens body and managem	sure that specific governing ent requirements are met.					
BORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	) JILE , F	6	(X6) DATE	
_Cau	Marce !-	Klee Pri	egsa	m/ William 5-	8-0	<u> 28                                    </u>	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G037	B. WING		04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER		38	EET ADDRESS, CITY, STATE, ZIP CODE B15 ALBERMARLE STREET NW (ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	· (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 102	This CONDITION The facility's goven	is not met as evidenced by: ning body failed to maintain	W 102	Cross reference W104		5/5/08
	general operating of ensure the provision clients' health and s The results of these	firection over the facility to a not active treatment and the safety [ See W104 and W127].				
W 104	govern the facility in clients' were free fr 483.410(a)(1) GOV		W 104		·	
	budget, and operate This STANDARD	y must exercise general policy, ting direction over the facility.  is not met as evidenced by: tion, interview and record				
	review, the facility's monitor and/or revi ensure the facility's and provided for th active treatment se	is Governing Body failed to ise its operation directions to senvironment was appropriate the health and safety as well as ervices for one of the four notuded in the sample.				
	The finding include					·
	2008 at approxima entering the facility assistance of two side of the client) to that was located in staff on April 2, 200 revealed that Client least two people to	residential facility on April 2, tely 4:41 PM revealed Client #1 i. The client required the direct care staff (one on each o ambulate to the recliner chair in the living room. Interview with 08 at approximately 5:02 PM at #1 required the support of at a ascend the exterior front a enter the facility. Staff further				

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#### PRINTED: 04/25/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B, WING. 09G037 04/04/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3815 ALBERMARLE STREET NW** CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (35) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 104 W 104 Client #1's DDS case manager Continued From page 2 submitted a referral for a revealed that Client #1 sometimes must be carried up the stairwell. barrier free environment on 04/08/08. CMS, Inc. Program Observation of at the residential facility on April 4, Director submitted a letter to 2008 at approximately 3:44 PM revealed Client #1 Client #1's case manager, attorentering the facility with the assistance of three staff members. The staff were positioned behind, ney, and guardian to identify to the right, and in front of Client #1 in order to a barrier free facility for assist him into the facility. While ambulating from Client #1. The facility will the front entrance to the recliner chair, the client communicate with DDS twice a was observed to have the assistance of two staff persons. month to follow-up on Client#1's 5/05/08 placement. interview was conducted with the Qualified Mental Retardation Professional (QMRP) and former House Manager (HM) on April 4, 2008 at 5:26 PM to ascertain information about the aforementioned concern regarding Client #1 's ambulation into/out of and around the facility. According to the interview, Client #1 was being assessed to transition to another residential placement. The QMRP revealed that on March 12, 2008 the Interdisciplinary team initiated a plan that would include Client #1 moving to a more barrier free environment. The plan consisted of acquiring a physical therapy assessment, obtaining a neurological evaluation and a cardiology evaluation. The team further agreed to reconvene regarding the matter in thirty days. It should be further noted that the former HM revealed that the facility had been meeting with the Department of Disability Services (DDS) since 2006 regarding Client #1 transitioning out of the

facility. Continued interview with the former HM revealed that since 2006 Client #1's case manager has changed and the change caused a delay in his transition into another home. The former HM also revealed that the client's functioning had decreased within the past year.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		09 <b>G</b> 037	B. WING	<u></u>		04/04	4/2008
NAME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CIT 3815 ALBERMARLE WASHINGTON, D	STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECT RECTIVE ACTION SHO RENCED TO THE APPR DEFICIENCY)	ULD BE	(YE) COMPLETION DATE
W 104	PM also revealed the barrier free environ. Review of Client #1 5:25 PM revealed a dated August 2, 200 the assessment, the "locate a facility that placement." At the governing body faile regarding Client #1 adequately address barrier free living er	urse on April 3, 2008 at 6:00 hat Client #1 needed a more ment.  's records on April 4, 2008 at a social work assessment of. According to the review of the consultant recommended to a same of the survey, the led to ensure the matter is new placement had been sed in order to provide a more nvironment.	W 10				
W 120	OUTSIDE SOURCI	sure that outside services	W 12	20			
,	Based on observati review, the facility for services met the ne	s not met as evidenced by: ion, interview and record alled to ensure that outside eds of two of four clients at #4) included in the sample.	·	-		:	
	The findings include	<del>2</del> ;					
	staff provided Clien	d to ensure the day program t #1 with meals that were ance with his prescribed	-				
	April 2, 2008 at app interview revealed ( sticks, creamed cor	dinner meal on the evening of proximately 5:47 PM and staff Client #1 was served fish m, collard greens, milk, water nt #1's meal was pureed and	,				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) N A, EU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
	,	09G037	B. Wil	NG		04/0	4/2008
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
				3	815 ALBERMARLE STREET NW		
CM5				l v	WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERÊNCED TO THE APP DEFICIENCY)	OUTO BE	(X5) COMPLETION DATE
W 120	Continued From pa	go 4	10/	120			
44 120	-	-	VV	120			
		thickened. A staff member			<u>.</u>	-	
		ed to be situated next to the			,		
İ		al. It should be noted that the leaved to be edentulous.					
		's April 2008 Physician's					. i
		108 at 4:47 PM revealed he					
		w sodium, low fat, low			·		
		diet and thickener was to be					,
	added to his liquids				· ·		
	Observation at Clie	nt#1's day program on April 4,			-		1
	2008 at approximat	ely 11:46 AM revealed the				•	
		ible in a room eating lunch					
	with his peers. Clos	ser observation and interview					
	with the day program	m staff revealed the client was					,
		ded fish fillet, macaroni and			•		-
	cheese, juice and n	nilk. It should be noted					
	however, that Clien	t#1's fish fillet was cut up into					,
	bite sized pieces; th	e macaroni and cheese and					
		d greens were portioned and					
		special modifications to their ency as required by Client #1's					
		inued observation revealed					1
		ent in the dining room but					
		e room. Day program staff					. !
		o be continuously by his side					
	during the lunch.	, , , , , , , , , , , , , , , , , , ,			· '		<u> </u>
	While the Client #1	was eating his lunch, the day					1
	program staff monit	toring the meal was asked if			1		1
		he client's dietary order and					1
		t had not received the correct					
		staff person acknowledged the					1
		ras a pureed diet with					1
	thickened beverage	es, but failed to intervene with					1
		order to provide the client with					1
		I diet. Due to the staff	,				

texture concern, the staff member was asked

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	COMPLE	TED
•		09G037	B. WING _		04/04	1/2008
NAME OF P	PROVIDER OR SUPPLIER	:	3	REET ADDRESS, CITY, STATE, ZIP COI 815 ALBERMARLE STREET NW VASHINGTON, DC 20008	DE	
(X4) ID PREF(X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 120	who was responsite meals at the day properlied that it was to staff member at the indicated that the rethe kitchen.  Interview was concresponsible for preduced at 11:52 Alaware of Client #11: According to that so was to be pureed of further revealed at kitchen, that indicate No Added Salt (NA pureed diet with the member was informed that was servented.)	lige 5 le for preparing the clients' rogram. The staff member the responsibility of another eday program and further esponsible staff person was in lucted with the staff person paring Client #1's meal on April W to ascertain if she was a prescribed dietary order. It taff person Client #1's meal or chopped. The staff member document, located in the ted Client #1 was to receive a a.S.), low fat, low cholesterol ckened liquids. When the staff med of the consistency of the ed to Client #1, she indicated e manner it was served.	W 120	H. A meeting was held #1's day program on 0% Client #1's diet was a The facility requested be trained on Client# feeding protocol, and supervision prior to return to the program program trained their provided an activity Client #1. In the fut QMRP will make unannotat Client #1's day priunch to ensure they his diet.	4/10/08. reviewed. d that staf. l's diet, wone to one Client #1's . The day staff and schedule fo ure, the unced visit ogram durin	r
	nurse on April 4, 20 Client #1 was to ha at risk for aspiratio informed that Clier prescribed, she imfrom eating and tol prepare another mhis dietary order (psurvey, the facility program provided with his prescribed W127)  2. The facility faile	fucted with the day program 1008 at 12:04 PM that revealed are a pureed diet due to being in. When the nurse was at #1's meal was not served as mediately stopped the client d the kitchen staff person to eal for him in accordance with ureed). At the time of the failed to ensure the day Client #1's meal in accordance dietary order. (See also d to ensure infection control ystematically implemented at				

U4/Z3/ZUU5 U4:ZZ PAA ZUZ44C54JU

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		09G037	H. WING_		04/0	4/2008
NAME OF F	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP COD 1815 ALBERMARLE STREET NW NASHINGTON, DC 20008	E	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
W 120	2008, beginning at fingernails were mis The exposed area of discolored (brownis interviewed on Apri ascertain if they we aforementioned obtainstructed the surve program nurse.  Interview with the discolored of the missin notified of the obsections #4's thumbs infected.	nt #4's day program on April 3, 10:06 AM revealed the client's saing on both of his thumbs. on each thumb appeared to be in pink). Staff were I 3, 2008 at 10:35 AM to re aware of the servation (no thumb nails), that they were not aware that also on his thumbs and eyor to talk with the day ay program nurse on April 3, evealed that the nurse was not by thumb nails. After being evation, the nurse examined and revealed that they were	W 120	2. A meeting will be Client #4's day progr Infection Control and Client #4's goal to p contamination.	am to disc revising	uss 5/23/08
W 122	on April 3, 2008, at assisting with setting client was observed and Dycem mats or setting the items or disseminating them client was observed mouth. Staff witnes the client to the resultent then returned at each place setting however, that the distributed in the provide any protect hands to prevent the		W 122			

	MENT OF HEALTH	AND HUMAN SERVICES					PPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			TON TON	OMB NO. (X3) DATE SU	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLET	
WD SDW OF	CORRECTION		1				
	•	09G037	B. WIN			·· <del>··················</del> ·	/2008
NAME OF PE	ROVIDER OR SUPPLIER	<del></del>		STRI 38	EET ADDRESS, CITY, STATE, ZIP COD 815 ALBERMARLE STREET NW	Ē	
CMS					ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	ACACH DESIGNENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 122	Continued From pa The facility must en protections require	nsure that specific client	W	122	Cross reference W120, W249, W104, W249	W148, W149	6/8/08
	•						
	Based on observatoreview, the facility safety of each client were served in according to the safety of each client were served in according to the safety of each client was afterned to the safety of	is not met as evidenced by: tion, interview and record failed to ensure the health and int by making certain all meals cordance with prescribed were notified of serious 48]; failed to implement policies at ensured clients' health and is and failed to ensure that all in source were reported [See insure that prior to the use of chniques, the client's record programs incorporating less es had been attempted and the W278]; failed to provide inment to ensure client's health in 104]; and failed to provide 1:1					
W 124	[W249]. The effects of the the failure of the factors their health.	sure clients' health and safety se systemic practices results in acility to protect its clients and to h and safety. OTECTION OF CLIENTS		V 124	4		
	Therefore the factories parent (if the client of the client's means behavioral s	ensure the rights of all clients. ility must inform each client, it is a minor), or legal guardian, dical condition, developmental tatus, attendant risks of the right to refuse treatment.		٠.			

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED	
THE POST	) कर्काश्चरमञ्जूषा । स्वतः २	09G037	B. WING			04/0	4/2008
NAME OF P	ROVIDER OR SUPPLIER			3815 A	ADDRESS, CITY, STATE, ZIP CODE L BERMARLE STREET NW HINGTON, DC 2000B		
(X4) ID PREFIX TAG	JEACU SIEGICIENIC	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	CONTO RF	(XS) COMPLETION DATE
W 124	Confinued From pa	age 8	W 12	24		-	
,	Based on interview failed to ensure the their legal guardian medical condition, status attendant ri	is not met as evidenced by:  and record review, the facility enghts of each client and/or to be informed of the client's developmental and behavioral sks of treatment, and the right t for one of the four clients d in the sample.				•	
	informed consent and/or his legal gu	o provide evidence that was obtained from Client #3 erdian for an increase in chotropic medication.					
	Observation of the administration on 7:15 PM revealed including Seroque Hydrochloride 50 medication nurse administration rev	e evening medication  April 2, 2008 at approximately  Client #3 received medications  I FC 400 mg and Naltrexone  mg. Interview with the  during the medication  ealed the aforementioned  used to address the client's	-	-			
	on April 2, 2008 a #3 did not have th consent for the us habilitation servic was verified on A review of Client # dated July 9, 200 Client #3 "does n decisions on his	former House Manager (HM) to 9:40 AM revealed that Client to capacity to give Informed se of medications and es. The former HM's statement pril 4, 2008 at 12:39 PM through 3's psychological assessment of evidence the capacity to make own behalf regarding granting, withdrawing consent to medical					

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 04/04/2008 09G037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ίĐ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 124 W 124 Continued From page 9 treatments: regarding treatments other than medical, regarding habilitation, day programming or work: regarding type and place of residence; regarding finances, and/or regarding life planning; and he does not have the capacity to execute a durable power of attorney." Additionally, continued interview with the HM on April 2, 2008 revealed that Client #3 did not have a legal guardian. The farility is currently awaiting Review of Client #3's medical record on April 3, for a limited guardianship hearing 2008 at 5:30 PM revealed a written physician's order dated July 12, 2007 that documented to for Client #3. At the hearing a increase the client's Seroquel to 300 mg twice a limited guardian will be identified. day (previous order indicated Client #3 received The QMRP will continue to follow-Seroquel 100 mg in the morning and 200 mg in up with Client #3's case manager the evening). Continued review of Client #3's. written physician's orders revealed an additional weekly regarding the status. increase in the the client's Seroquel on October Meanwhile, the QMRP will contact 11, 2007 to 400 mg twice daily. Interview was Client #3's father to get consent conducted with the Qualified Mental Retardation for the use of psychotropic Professional (QMRP) on April 3, 2008 at 5:40 PM 5/14/08 medication. that revealed that Client #3's medication was increased due to an increase in the client's exhibited behaviors. The QMRP was then queried to ascertain if Client #3 and/or his legally authorized representative was informed of the medication increases and to determine if consent was obtained for the medication changes. The OMRP revealed that there were consents

obtained from Client #3's father located in his record. However, review of Client #3's record and

provide evidence that any type of consent (written and/or informed) had been obtained prior to the aforementioned psychotropic medication

increases. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the Client #3 and/or legally

further discussion with the QMRP failed to

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 04/04/2008 09G037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008 CMS PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 124 Continued From page 10 W 124 authorized representative for the increase in his psychotropic medications. 5/14/08 Cross reference W124 483.420(a)(3) PROTECTION OF CLIENTS W 125 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risk of treatment, and the right to refuse treatment for one of four clients (Client #3) in the sample. The finding includes: The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. [See W124] W 127 483.420(a)(5) PROTECTION OF CLIENTS W 127 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by:

Based on observation, interview and record

04/25/2008 04:23 FAX 2024428430

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DEPARTMENT OF HEALTH A	ND HUMAN SERVICES
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	(XZ) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		096037	B, WING_		04/04/2008
NAME OF P	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 815 ALBERMARLE STREET NW VASHINGTON, DC 20008	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 127	safety of one client were served in act dietary orders, for #1) included in the The facility failed to program provided	failed to ensure the health and to by making certain all meals cordance with prescribed one of the four clients (Client	W 127	Cross reference W120 #1	05/05/0
	of April 2, 2008 at staff interview reversibles, creame water and peache and his beverages member was furth to the client during that the client was edentulous. Review Physician's Order revealed he was peach at the client was revealed he was peach at the client was edentulous.	the dinner meal on the evening approximately 5:47 PM and ealed Client #1 was served d com, collard greens, mllk, s. Client #1's meal was pureed were thickened. A staff ler observed to be situated next also observed to be ew of Client #1's April 2008 s on April 3,2008 at 4:47 PM prescribed a low sodium, low fat, reed diet and thickener was to			
·	2008 at approximal client seated at a with his peers. Clienth the day progreating greens, bracheese, juice and however, that Clienth bite sized pieces; the prepared collars.	ent #1's day program on April 4, ately 11:48 AM revealed the lable in a room eating lunch oser observation and interview am staff revealed the client was saded fish fillet, macaroni and milk. It should be noted ent #1's fish fillet was cut up into the macaroni and cheese and ord greens were portioned and y special modifications to their			

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PRINTED: 04/25/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XZ) MULTIPLE CONSTRUCTION DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G037 04/04/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ın (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W 127 Continued From page 12 W 127 form and/or consistency as required by Client #1's distany order. Continued observation revealed that staff were present in the dining room but intermittently left the room. Day program staff was not observed to be continuously by his side during the lunch. While the Client #1 was eating his lunch, the day program staff monitoring the meal was asked if she was aware of the client's dietary order and aware that the client had not received the correct textured diet. The staff person acknowledged the client's dietary order as a pureed diet with thickened beverages, but failed to intervene with the served meal in order to provide the client with the correct textured diet. Due to the staff members failure to address the observed food texture concern, the staff member was asked who was responsible for preparing the clients' meals at the day program. The staff member replied that it was the responsibility of another staff member at the day program and further indicated that the responsible staff person was in the kitchen. Interview was conducted with the staff person responsible for preparing Client #1's meal on April 4, 2008 at 11:52 AM to ascertain if she was aware of Client #1's prescribed dietary order. According to that staff person Client #1's meal was to be pureed or chopped. The staff member further revealed a document, located in the kitchen, that indicated Client #1 was to receive a No Added Salt (NAS), low fat, low cholesterol pureed diet with thickened liquids. When the staff

member was informed of the consistency of the meal that was served to Client #1, she indicated he could eat it in the manner it was served.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	ì
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLET		
	•	09G037	B, Wil			04/04/	2008
NAME OF P	ROVIDER OR SUPPLIER		_	381	ET ADDRESS, CITY, STATE, ZIP CODE IS ALBERMARLE STREET NW ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)		(X3) COMPLETION DATE
W 127	nurse on April 4, 20 Client #1 was to he at risk for aspiration informed that Client prescribed, she imfrom eating and toler prepare another mis dietary order (p. B. Interview was of facility's former Ho Qualified Mental (QMRP) on April 4 Client #1's dietary why the client was thickened beverag Client #1 received liquids due his risk Review of Client # approximately 7:31 language evaluation According to the a history of aspiration Banium Swallow initiation." assessment revea documented, "one mealtimes is need documented that "blenderized pure foudding consisted	lucted with the day program 1008 at 12:04 PM that revealed are a pureed diet due to being in. When the nurse was at #1's meal was not served as mediately stopped the client of the kitchen staff person to eal for him in accordance with aureed).  Conducted with the residential cuse Manager (HM) and etardation Professional 2008 at 5:13 PM to verify order and ascertain the reason prescribed his pureed diet with es. According to the HM, a pureed diet with thickened for aspiration.  1's records on April 4, 2008, at 5: PM revealed a speech and on dated August 1, 2007. It is east conducted in May on Hospital Center. A moderate se of swallow was detected, sking were noted to occur after a Continued review of the siled a recommendation that e to one supervision at led." The assessment also client #1 tolerated a ed diet with thickened liquids ncy)." It further described his es and indicated that he had		127			
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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. (	PPROVED 1938-0391
TATEMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		EE OCHOTICOSTI	X3) DATE SUI COMPLET	RVEY ED
	,	09G037	B. WIN			04/04	/2008
	ROVIDER OR SUPPLIER		,	38	ET ADDRESS, CITY, STATE, ZIP CODE 15 ALBERMARLE STREET NW		
CMS		•		· W	ASHINGTON, DC 20008		<u></u>
(X4) ID PREFIX TAG	(EACH DESIGNENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE [	(X5) COMPLETION DATE
W 127	Continued From pa	nge 14	W.	127	Cross reference W120 #1		5/5/08
	Note: The QMRP of 5:28 PM of the Stathe day program's meals in accordance	was notified on April 4, 2008 at the Agency's determination that failure to provide Client #1 with the with his prescribed dietary					
	order. This failure posed a serious ar #1's health and saf onsite until the faci immediate jeopard prohibited Client #	resulted in neglect which ad immediate threat to Client ety. The surveyors remained lity addressed the serious and y by initiating a plan that its return to the day program service at the program was					
W 148	addressed. The st	upport was designed to protect ential harm. MMUNICATION WITH	w	148	In the fature, Client #6 guardian with be notified there is an incident inv	d when	
· .	parents or guardia	otify promptly the client's n of any significant incidents, or ent's condition including, but not illness, accident, death, abuse, osence.			the facility. The facili contact the individuals' family when there is an	guardia	
	Based on interview	is not met as evidenced by: w and record review, the facility arents/guardians were notified ts, for one of four clients (Client facility.					
	The finding includ	es:	,				
	2008 beginning at involving Client #6 According to the radministered Clie was conducted w	lity's incident reports on April 2, 10:23 AM revealed an incident dated June 29, 2007. The port, Client #6 was nt #7's medications. Interview ith the former House Manager 1008 at 9:40 AM that revealed a brother that was his legal		:			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	
		09G037	B. WING_		04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER		3	EET ADDRESS, CITY, STATE, ZIP CO B15 ALBERMARLE STREET NW VASHINGTON, DC 20008	)DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(XS) COMPLETION DATE
W 148	guardian and was i time of the survey, documented evide	ige 15 nvolved with his care. At the however, there was no noe that revealed Client #6's d of the aforementioned	W 148			
W 149	CLIENTS  The facility must de policies and proced	FF TREATMENT OF evelop and implement written dures that prohibit ect or abuse of the client.	W 149	In the future, the factorial ensure that all inci- reported in a timely management staff will additional training incident management	dents are manner. The l recieve on the	6/3/08
	Based on interview failed to implement client's health and	is not met as evidenced by:  and record review, the facility policies that ensured the safety, for one of the four noluded in the sample. e:				
		ensure the timely reporting of nented in its "Incident by	·			
	2008 beginning at involving Client #7	ty's incident reports on April 2, 10:23 AM revealed an incident dated February 11, 2008 port, Client #7 was discovered rehead.				
	Manager (HM) on a ascertain informati incident managem former HM, incide administrator. The verified on April 2, AM when the facilit	flucted with the former House April 2, 2008 at 10:35 AM to on regarding the facility's ent system. According to the office to be reported to the former HM's statement was 2008 at approximately 11:00 by's incident management onding protocol were reviewed.				

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Υ
	_	09 <b>G</b> 037	E. WING_	-	04/04/20	808
NAME OF F	PROVIDER OR SUPPLIER		3	REET AODRESS, CITY, STATE, ZIP CODE 1815 ALBERMARLE STREET NW VASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DE CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APER DEFICIENCY)	NUDBE COL	(X5) MPLETION DATE
W 149	According to the pro- Reportable Incident notifications were to that documented in Review of the facilit policy documented be verbally notified.  At the time of the su failed to provide evi was notified of the su W153). Additionally evidence that the in and protocol were in 483.420(d)(2) STAF CLIENTS  The facility must en mistreatment, negle injuries of unknown immediately to the so officials in accordan established procedu  This STANDARD is Based on interview failed to ensure that source were immed administrator or to o	brocol entitled "Serious s," immediate verbal to be completed for incidents juries of unknown origin. Ys incident management that the administrator was to unvey however, the facility dence that the administrator atomentioned incident (See of the facility failed to provide cident management policy inplemented as outlined. FTREATMENT OF sure that all allegations of ect or abuse, as well as source, are reported administrator or to other acce with State law through	W 149	Cross reference W149	06,	/3/08
	#6) that resided in the finding includes	·				
_	2008, beginning at involving Client #7 of	y's incident reports on April 2, 10;23 AM revealed an incident lated February 11, 2008. port, Client #7 was discovered	-			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2008 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E dollo mod no.	X3) DATE SURV COMPLETED	
-		09G037	B. WING		04/04/2	8008
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	38	ET ADDRESS, CITY, STATE, ZIP CODE 15 ALBERMARLE STREET NW ASHINGTON, DC 20008	·	
(X4) ID PREFIX TAG	(EVCR DEBICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE   C	(X5) OMPLETION DATE
W 153	Continued From pa with a cut on his fo	rehead.	W 153			
W 159	Manager (HM) on ascertain informati incident managem former HM, all incident meaninistrator. The administrator report however, redocumented evide administrator had the survey, the fact that ensured the anotified of the aformation information and the aformatical meanings.	ducted with the former House April 2, 2008 at 10:35 AM to on regarding the facility's ent system. According to the dents were to be reported to Further review of the incident vealed that there was no noce that indicated the been notified. At the time of ility failed to provide evidence dministrator was immediately ementioned incident.  FIED MENTAL ROFESSIONAL	W 159			
	integrated, coording	e treatment program must be nated and monitored by a stardation professional.				-
	Based on observa review, the facility active treatment p coordinated and n Mental Retardatio	is not met as evidenced by: tion, interview and record failed to ensure each client's rogram was integrated, nonitored by the Qualified n Professional (QMRP), for lients (Clients #1, #2, and #4) facility.				
	effectively trained Behavior Support	led to ensure staff were to implement Client #3's Plan. [See W194]		1. The facility will trastaff on Client #3's BSI vention strategies, and umentation on 5/23/08.	, inter-	5/23/08
	2. The QMRP fail functional assess	ed to ensure a comprehensive ment of behavioral needs was		2. Cross reference W214		5/14/08
1				<u> </u>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2008 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	·		
	•	09G037	B. WING		04/04/	/2008
NAME OF P	ROVIDER OR SUPPLIER		38	EET ADDRESS, CITY, STATE, ZIP CODE 115 ALBERMARLE STREET NW (ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	CAOU DEDOIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	conducted for Clie	nt #4. [See W214]	W 159	3. Cross reference W22	29	5/14/08
	documented in the	ed to ensure objectives Individual Program Plan (IPP) ately, in terms of a single le for Client #3. [See W229]			·	5/14/08
	received continuor	ed to ensure that Client #3 us active freatment services rentions. [See W249]		4. Cross reference W2	,	
	use of more restri	led to ensure that prior to the ctive techniques, the client's led that programs incorporating iniques had been attempted and [See W278]	·	5. Cross reference W2	49	5/14/08
. •	behavior support	led to ensure Client #3's plan and corresponding data vere effectively monitored.	,	6. The facility will staff on Client #3's vention strategies, a tation on 5/23/08. In	BSP, inter- nd documen-	
	records on April 4 client had a Beha November 26, 20 Client #3 had cha non-compliance, spitting, hoarding	QMRP and review of Client #3's p. 2008 at 12:39 PM revealed the vior Support Plan (BSP) dated 07. The plan documented that allenging behaviors of physical aggression, eloping, masturbation, repetitive others and pulling his hair.		the QMRP will review data monthly to ensur documentation.	the Clients	
	revealed intervent redirection and to Client #3 with his According to the be used by staff engage in and/or targeted behavior	of the BSP on April 4, 2008 ation strategies (verbal buch control) were used to assist challenging behaviors plan, verbal redirection was to whenever Client #3 was about to engaged in any one of his irs. The plan further indicated by was to be utilized if the verbal				

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PRINTED: 04/25/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 04/04/2008 **n9G037** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3B15 ALBERMARLE STREET NW WASHINGTON, DC 20008 CMS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRUSS-REFERENCED TO THE APPROPRIATE (XS) MPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG W 159 Continued From page 19 W 159 redirection did not work and only if the situation was serious or important. The plan cautioned that touch control "should be a last resort" and used "only if quick action is required." The plan additionally documented that staff were responsible for documenting the "total frequencies of [Client #3's] behaviors and the frequencies of staff intervention steps" on the behavioral data sheet. Review of the corresponding data collection forms on April 4, 2008 at 10:32 AM revealed evidence that Client #3 exhibited challenging behaviors monthly. The data collection form was designed for staff to document the frequency that each behavior occurred and the intervention strategy (either verbal redirection or touch control) that was used. Continued review of the data collection forms however, revealed several occasions where intervention strategies were not utilized in accordance with Client #3's BSP when targeted behaviors were exhibited. For example: a. May 7, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of hoarding items, 2 incidents of pulling his hair, 1 incident of repetitive fiddling with objects, 2 incidents of non-compliance, and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that one instance of touch control was the only intervention utilized. b. May 12, 2007 (12:00 AM to 8:00 AM shift) -The data collection form documented that Client

#3 engaged in 1 incident of repetitive fiddling with objects, 1 incident of spitting on people and 3 incidents of inappropriate masturbation.

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION DENTIFICATION NUMBER:		1''	ultipi Lding	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G037	B. WIN	IG		04/04	4/2008
NAME OF P	ROVIDER OR SUPPLIER			391	ET ADDRESS, CITY. STATE, ZIP CODE 15 ALBERMARLE STREET NW ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IONTO BE	COMPLETION DATE
W 159	aforementioned da strategies were imp c. May 22, 2007 (1 The data collection	strategy documentation for the te revealed no intervention plemented.  2:00 AM to 8:00 AM shift) - form documented that Client	W	159			
·	incidents of spitting inappropriate mast intervention strateg aforementioned da	cidents of pulling his hair, 3 yon people and 2 incidents of urbation. Review of the youngentation for the terevealed that touch control and intervention utilized.					
	The data collection #3 engaged in 1 income a incidents of inapproperation for the aforementic	12:00 AM to 8:00 AM shift) - a form documented that Client cident of spitting on people and propriate masturbation. vention strategy documentation and date revealed that touch a) was the only intervention					
-	The data collection #3 engaged in 3 in and 3 incidents of Review of the interfor the aforementic	12:00 AM to 8:00 AM shift) -  to form documented that Client cidents of spitting on people inappropriate masturbation. Vention strategy documentation oned date revealed no gles were implemented.	·				
	data collection for engaged in 3 incidents of pulling fiddling with object non-compliance, 3 others and 3 incide behavior. Review	8:00 AM to 4:00 PM shift) - The n documented that Client #3 ents of hoarding items, 4 his hair, 1 incident of repetitive s, 4 incidents of aggression to ents of elopement related of the intervention strategy the aforementioned date					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2008 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BU		PLE CONSTRUCTION	COMPLE	
		09 <b>G</b> 037	B. Wii	NG		04/04	4/2008
NAME OF P	ROVIDER OR SUPPLIER			38	EET ADDRESS, CITY, STATE, ZIP CODE M5 ALBERMARLE STREET NW (ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 159	implemented. g. May 31, 2007 (* The data collection #3 engaged in 1 in	ention strategies were  12:00 AM to 8:00 AM shift) -  1 form documented that Client cidents of hoarding items.	W	159			
	for the aforementic intervention stratec	vention strategy documentation and date revealed no gies were implemented.  3:00 AM to 4:00 PM shift) - The					
	data collection for engaged in 3 incidents masturbation. Revidencementation for	in documented that Client #3 lents of inappropriate view of the Intervention strategy the aforementioned date ention strategies were					
-	The data collection #3 did not engage	12:00 AM to 8:00 AM shift) - I form documented that Client in any of his largeted behaviors vas used as an intervention					
	The data collection #3 did not engage people Review of documentation for	(12:00 AM to 8:00 AM shift) - n form documented that Client of in 8 incidents of spitting on if the intervention strategy the aforementioned date ention strategies were					
W 194	provide evidence t monitored Client # collection and/or to intervention strate in accordance with	survey, the facility failed to hat the QMRP effectively 3's BSP to ensure that the data he implementation of gies were completed/conducted the BSP.  AFF TRAINING PROGRAM	w	194		· ·	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BU		· <del></del>	(X3) DATE SURVEY COMPLETED	
	·	09G037	B. WI	/G_		04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER	<del>-</del> · · · · · · · · · · · · · · · · · · ·		33	EET ADDRESS, CITY, STATE, ZIP CODE 115 ALBERMARLE STREET NW /ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES FMUST BE PRECEDED BY FULL SCIDENT(FYING INFORMATION)	ID PREP TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETION DATE
W 194	techniques necessa program plans for e responsible. This STANDARD i	to demonstrate the skills and ary to implement the Individual each client for whom they are s not met as evidenced by:	W	194			
	of records, the facil competency in the Individual Program clients included in t The finding include The facility failed to direct care staff we	provide evidence that the re able to demonstrate implementation of Client #3's					
	PM revealed the cli room with a plastic was observed to op times. The client w index finger in the across his lower lip should be noted the	ent #3 on April 2, 2008 at 5:12 lient standing in the dining egg in his hand. The client pen and close the egg several was also observed inserting his egg then rubbing his finger on several occasions. It at at least one direct care staff itnessed the activity.					
	Professional (QMR records on April 4, client had a BSP da plan documented to challenging behavior the plan further do	Qualified Mental Retardation (P) and review of Client #3's 2008 at 12:39 PM revealed the ated November 26, 2007. The hat Client #3 had several ors including repetitive fiddling, becomented strategies that se of verbal redirection and/or if					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(XZ) MUL	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		19G037	B. WING	<del></del>	04/0	4/2008
NAME OF FI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE ZIP COD 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	<u>.                                    </u>	
(X4) ID PREFIX TAG	(EACH DESICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
W 194	engaged in any of land Additionally, the plastaffing supports at with addressing all During the aforement observed to introduce the client's fiddling. Further, Client #3 we staffing supports at the time of the sunstaff were able to complement Client # consistently and as 483,440(c)(3)(iii) If the comprehensive	ontrol whenever Client #3 his targeted behaviors. In included the use of 1:1 t all times to assist the client of his targeted behaviors entioned observation, staff was ervene and/or address the orthermore, throughout the ras not observed to have 1:1 t all times. (See also W249). At orey, the facility failed to ensure demonstrate skills necessary to all sehavior support plan soutlined. NDIVIDUAL PROGRAM PLAN ore functional assessment must especific developmental and	W 15			5/14/08
٠.	Based on interview failed to ensure a casessment of bell	is not met as evidenced by: v and record review, the facility comprehensive functional havioral needs was conducted ints (Client #4) included in the				
	The finding include	es:				
	The facility failed thumb-sucking be	o assess Client #4's havior.				
	home between 4:4	Client #4 was observed in the 16 PM and 6:31 PM. At 5:14 the client was observed sucking		-		
	The client was obs	served on April 3, 2008 in his			<del>,</del>	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	NPPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY 'ED
	-	09G037	B. WIN	1G		04/04	/2008
NAME OF PE	ROVIDER OR SUPPLIER			STR 38	EET ADDRESS, CITY, STATE, ZIP CODE B15 ALBERMARLE STREET NW		
CMS		·			ASHINGTON, DC 20008	TON .	
(X4) ID PREFIX TAG	(EVCH DEEKJENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W.214	At 10:11 AM, an in	en 10:02 AM and 11:06 AM. erview was conducted with the	W		The facility psychologis clarify, revise, and exp Client #4's BSP of thumb	and	5/14/08
	client's day program classroom coordina program case man Support Plan (BSP behaviors of aggre behavior (handbitin regarding the clien thumbsucking, the classroom coordin	n case manager and ator. According to the day ager, Client #4 had a Behavior ) that included targeted ssion and self-injurious ag). When further queried t's exhibited behavior of case manager and the ator both reported that they had lient sucking his thumbs.					
	observation of the April 3, 2008 betwee revealed the client several occasions, staff in the lunch re observed to suck I	however, that continued client at the day program on the deen 10:42 AM and 10:56 AM sucked his right thumb on the At 11:00 AM, while assisting from, Client #4 was not only his thumbs but he was the attention of the country of the c	-				
	6:42 PM with the f who confirmed tha thumb, however, t the behaviors targ interview with the	conducted on April 2, 2008 at acility's former house manager at the client routinely sucked his humb sucking was not among eted in his BSP. Furthermore, facility's Registered Nurse #4's thumbsucking was a					
W 229	provide evidence thumbsucking bel addressed as war 483,440(c)(4)(i) IN	IDIVIDUAL PROGRAM PLAN	V	V 22	9		
	The objectives of must be stated se	the individual program plan parately, in terms of a single					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		09G037	B. WING_		04/04	1/2008	
NAME OF P	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP ( 815 ALBERMARLE STREET NW VASHINGTON, DC 20008	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 229	Continued From pa behavioral outcome	<b>).</b>	W 229				
	Based on observat facility failed to ens the Individual Progr separately, in terms	s not met as evidenced by: ion and record review, the ure objectives documented in ram Plan (IPP) were stated s of a single behavioral f the four clients (Client #3) uple		The facility's psych revise Client #3's B objective to list it therefore it could b	ehavioral separately	5/14/08	
	PM revealed the clibehavior. Review of record on April 4, 2 Behavior Support F 26, 2007. According challenging behaviothers, hoarding, pothers, repetitive ficon people, and inaccontinued review only one objective was document.	ent #3 on April 2, 2008 at 5:19 ient exhibited repetitive fiddling of Client #3's habilitation 008 at 10:04 AM revealed a Plan (BSP) dated November og to the BSP Client #3 had ors that included touching ulling his hair, aggression to ddling, noncompliance, spitting opropriate masturbation. of the BSP revealed there was documented in the plan. The mented as "reduce viors to zero per month."					
W 249	Professional (QMR AM revealed that the inappropriate behalf each of the aforem behaviors. At the failed to ensure that objectives separate objective identified	Qualified Mental Retardation (P) on April 4, 2008 at 10:32 the one objective (reduce viors) was used to measure entioned challenging ime of the survey, the facility at Client #3's BSP documented ely, making certain that each a single behavioral outcome. (INTERPORT OF THE PROPERTY OF TH	W 249				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	PPROVED
TATEMENT	S FOR MEDICARE  OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
•		09G037	B. WI	1G		04/04	/2008
VAME OF P	ROVIDER OR SUPPLIER			381	ET ADDRESS, CITY, STATE, ZIP CODE 15 ALBERMARLE STREET NW		
CMS				WA	ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	CEACH DESIGNERS	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE (	DATE
W 249	Continued From pa	age 26	W	249			
	formulated a client each client must re treatment program interventions and s and frequency to s	erdisciplinary team has individual program plan, ecelve a continuous active consisting of needed services in sufficient number apport the achievement of the in the Individual program		· .			
	Based on observa review, the facility received continuo including needed	Is not met as evidenced by: ition, interview and record failed to ensure each client us active treatment services, interventions, for one of the four included in the sample.					•
	The finding includ	es:		:	·		
	The facility falled Behavior Support below:	to implement Client #3's Plan (BSP) as evidenced					
	at approximately former House Ma #3 received 1:1 s daily. The former #3 received the 1 the day program. was implemented addressing mala-	ce conference on April 2, 2008, 9:40 AM, interview with the inager (HM) revealed that Client upervision for eight (8) hours if HM further revealed that Client 1 staffing supports only while at The special staffing support if to assist Client #3 with daptive behaviors of elopement self injurious behaviors.					
	2008 (between 4	lient #3 on the evening of April 2 :31 PM and 6:35 PM) and lient #3 on April 3, 2008 at his					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			<u></u>	FORM A OMB NO. I	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(XZ) M	ULTIPLE	CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A, BUI	LDING			1
		09G037	B. WII	иG		04/04	/2008
NAME OF P	ROVIDER OR SUPPLIER	0.000		STREE	T ADDRESS, CITY, STATE, ZIP CODE		1
CMS					S ALBERMARLE STREET NW		
CMS	THE OF DEFINIONIES			WA T	SHINGTON, DC 20008 PROVIDERS PLAN OF CORREC	mon l	(7.5)
(X4) ID PREFIX TAG	CACH DESCIENCE	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE 1	COMPLETION
W 249	Continued From pa	age 27	W	249	<del></del> .	}	
W 2.10	day program (from	11:56 AM-12:14 PM) venified		-	•		1
	the aforementioner	i staffing supports. Client #3	•		•	•	1
	residential facility b	o have a 1:1 staff while in the out was observed to have the	'				
	assistance of the 1	:1 staff person while at the day		1		•	
	program.	•					
	on April 3, 2008 at	lucted with Client #3's 1:1 staff 12:08 PM to ascertain ing the 1:1's responsibilities. terview, the 1:1 staff revealed					
	that he/she provide Monday through F that Client #3 had	ed 1:1 support for Client #3 riday. The 1:1 further indicated behaviors of elopement and					
	aggression and ha client with address	ving 1:1 supports assisted me ing those behaviors.					
	Professional (QMi records on April 4, client had a Behan	Qualified Mental Retardation RP) and review of Client #3's 2008 at 12:39 PM revealed the nor Support Plan (BSP) dated	2				
	November 25, 200 Client #3 had chain non-compliance, pariting hearding.	D7. The plan documented that lenging behaviors of ohysical aggression, eloping, masturbation, repetitive others and pulling his hair.		-			
	Continued review entitled, "Need for section, the plan or primarily a danger without a 1:1 staff	of the plan revealed a section 1:1 Staffing." According to the locumented that "Client #3 is to himself and/or others berson at all times. He has a	at				
	his behaviors are weekends, upstai anywhere at anyti may at any mome he may arah ang	Impulse Control Disorder and unpredictable day, night, rs, downstairs, on the van and me. For example, [Client #3] ent suddenly attempt to elope other person sexually. To a less the may embarrass himself or	r		-		

#226 P. 030/065

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	04/25/2008 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER	(X2) MULT	TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLE	
,	-	09G037	A. WING		04/0	¥2008
<del></del> -	ROVIDER OR SUPPLIER		1	IREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW		
CMS				WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRE		()(5)
(X4) ID PREFIX TAG	(はんたい ロミログ)氏がこと	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE
W 249	anytime without a 1 behaviors around of etc [Client#3] do staff person is next him." The plan furt "[Client #3] is also a not properly redirect 1:1, as he may be a times. It should be information was for November 26, 200 previous BSP's dat August 9, 2007.  Review of the correbetween the month revealed the follow frequency of Client behaviors of elope others, pulling his lexample;  April 2007 - 1 incident of aggression.  June 2007 - 3 incident of aggression.  June 2007 - 1 incident of touching others and 21 incidents of Review of the facil Review forms on A revealed the client aforementioned cibelow:	t sexually or inappropriately at 11 staff person monitoring his others, in front of windows, as much better when a familiar to him, immediately next to the documented that the danger to others when he is sted by someone such as a more aggressive at these noted that the aforementioned and not only in the BSP dated 7 but also in Client #3's ted February 21, 2007 and esponding data sheets as of April 2007 and June 2007 ing information regarding the #3's exhibited challenging ment, Inappropriately touching hair and aggression. For lent of touching others and 78 his hair, ents of elopement, 3 touching as of pulling his hiair, 7 incidents of pulling his hair, faggression.  Sity Psychotropic Medication April 3, 2008 at 6:31 PM and		9		
•	July 2007 - 1 incid	ent of elopement related				

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PRINTED: 04/25/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 04/04/2008 09G037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION ഥ (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 249 OMRP will submit a package to W 249 Continued From page 29 behavior, 1 incident of touching others, 158 MAA requesting additional hours incidents of pulling his hair, and 8 incidents of for one-to-one services for aggression, Client #3. The facility will August 2007 - 1 incident of touching others, 69 increase Client #3's one-to-one incidents of pulling his hair, and 11 incidents of hours from 8 hours Mondayaggression. September 2007 - Z incidents of elopament Friday to waking hours Mondaybehavior, 4 incidents of touching others, 185 Sunday. 5/14/08 incidents of pulling his hair, and 7 incidents of aggression. NOTE: Review of Client #3's records on April 3. 2008, at approximately 5:31 PM revealed a written physician's order (dated July 12, 2007) that documented the client was to increase his Seroquel from 100 mg every morning and Seroquel 200 mg every evening to Seroquel 300 mg twice daily. Continued review of the client's record on April 3, 2008, at 5:40 PM revealed another written physician's order dated October 11, 2007. The order documented that the client was prescribed to start Seroquel 400 mg twice a day. Interview with the Licensed Practical Nurse (LPN) on April 3, 2008 at 9:25 AM verified that the client's medication had been increased due to an increase in exhibited behaviors. It should be also noted that review of the client's records revealed the client continued to engage in the aforementioned challenging behaviors through March 2008. October 2007 - 0 incident of elopement related behavior, 0 incident of touching others, 43 incidents of pulling his hair, and 0 incidents of

aggression.

November 2007 - 8 incident of touching others; 55 incidents of pulling his hair, and lincidents of

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDING IDENTIFIES |                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                        | (X2) MULTIP         | PLE CONSTRUCTION                                                                                   | (X3) DATE SURVEY<br>COMPLETED |                         |  |
|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------|-------------------------------|-------------------------|--|
|                                                                             |                                                                                                                                               | 09G037                                                                                                                                                                                                                                       | B. WING             |                                                                                                    | 04/04/2008                    |                         |  |
| NAME OF P                                                                   | ROVIDER OR SUPPLIER                                                                                                                           |                                                                                                                                                                                                                                              | 38                  | EET ADDRESS, CITY, STATE, ZIP CODE<br>315 ALBERMARLE STREET NW<br>VASHINGTON, DC 20008             |                               |                         |  |
| (X4) ID<br>PREFIX<br>TAG                                                    | (EACH DEFICIENC                                                                                                                               | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                                                                                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE COM                  | (X5)<br>PLETION<br>DATE |  |
| W 249                                                                       | behavior, 2 incider                                                                                                                           | age 30<br>) incidents of elopement<br>nts of touching others, 55<br>, his hair, and 4 incidents of                                                                                                                                           | W 249               |                                                                                                    |                               |                         |  |
|                                                                             | behavior, 1 incide incidents of pulling aggression. February 2008 - 1 incidents of pulling aggression. March 2008 - 0 in 1 incidents of touch | ncident of elopement related nt of touching others, 158 g his hair, and 8 incidents of incident of touching others, 69 g his hair, and 11 incidents of cidents of elopement behavior, ching others, 61 incidents of incidents of aggression. |                     |                                                                                                    |                               |                         |  |
| W 262                                                                       | At the time of the ensure Client #3 vactive treatment is address his challe 483.440(f)(3)(i) PCHANGE                                          | survey, the facility failed to<br>vas provided with continuous<br>ncluding needed supports to                                                                                                                                                | W 262               |                                                                                                    |                               |                         |  |
|                                                                             | inappropriate beh                                                                                                                             | avior and other programs that,<br>he committee, involve risks to                                                                                                                                                                             |                     |                                                                                                    |                               |                         |  |
|                                                                             | Based on intervie<br>failed to ensure the<br>psychotropic med                                                                                 | is not met as evidenced by: w and record review, the facility nat Client #3's increase in lication had been reviewed and Human Rights Committee                                                                                              |                     |                                                                                                    |                               |                         |  |
|                                                                             | The finding include                                                                                                                           | les:                                                                                                                                                                                                                                         |                     |                                                                                                    |                               |                         |  |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                           | (X2) MULTI                                                                                                                                                                                                                                                                                                                                                                                                                 | PLE CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED                                                                                                                                                       |                                               |  |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--|
| •                                                                                                   |                                                                                                                                                                                                                                           | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING _        |                                                                                                                                                                                     | 04/04/2008                                    |  |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER SUMMARY STA                                                                                                                                                                                                           | TEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                     | ID 33            | REET ADDRESS, CITY, STATE, ZIP CODE<br>815 ALBERMARLE STREET NW<br>VASHINGTON, DC 20008<br>PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH                                   |                                               |  |
| PRÉFIX<br>TAG                                                                                       | (EACH DEFICIENC) REGULATORY OR L                                                                                                                                                                                                          | ( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                  | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                                                                                                                          |                                               |  |
| W 262                                                                                               | Observation of the administration on A 7:15 PM revealed (including Seroquel Hydrochloride 50 medication nurse dadministration revealed)                                                                                                   | evening medication pril 2, 2008 at approximately client #3 received medications FC 400 mg and Naltrexone ng. Interview with the luring the medication caled the aforementioned used to address the client's                                                                                                                                                                                                                | W 262            | In the future, the QMRP ensure that Client #3's of psychotropic medicat be approved by the HRC it's administration. The present at the medic review to review Client of medication. | increase ion will prior to se HRC will cation |  |
|                                                                                                     | approximately 5:31 physician's order (documented the cliseroquel from 100 Seroquel 200 mg mg twice daily. Corecord on April 3, 2 another written phy 11, 2007. The ordwas prescribed to day. Interview with (LPN) on April 3, 2           | d's records on April 3, 2007, at PM revealed a written dated July 12, 2007) that dent was to increase his mg every morning and every evening to Seroquel 300 ntinued review of the client's 2008, at 5:40 PM revealed visician's order dated October er documented that the client start Seroquel 400 mg twice a the Licensed Practical Nurse 2008 at 9:25 AM verified that the had been increased due to an ed behaviors. |                  |                                                                                                                                                                                     |                                               |  |
|                                                                                                     | Professional (QMF<br>Human Rights Cor<br>minutes on April 4,<br>HRC meetings dat<br>August 6, 2007, Oc<br>29, 2007. Review<br>minutes for the afo<br>provide evidence t<br>Seroquel had beer<br>the time of the sur-<br>its HRC reviewed: | Qualified Mental Retardation RP) and review of the facility's nmittee (HRC) meeting 2008 at 9:48 AM revealed ed were held July 2, 2007, ctober 8, 2007 and November of the corresponding meeting rementioned dates failed to hat the increases in Client #3's a reviewed and approved. At vey, the facility failed to ensure and approved Client #3's cation increase prior to its                                         |                  |                                                                                                                                                                                     |                                               |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION .                                                                                     | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------|--|
|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | B. WING                  |                                                                                                        | 04/04                         | /2008                      |  |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 3                        | REET ADDRESS, CITY, STATE, ZIP CODE<br>815 ALBERMARLE STREET NW<br>VASHINGTON, DC 20008                |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| W 262<br>W 263                                                                                      | Continued From pa<br>administration.<br>483 440(f)(3)(ii) PE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | age 32<br>ROGRAM MONITORING &                                                                                                                                                                                                                                                                                                                                                                                                                                           | W 262<br>W 263           |                                                                                                        |                               |                            |  |
|                                                                                                     | are conducted only consent of the clien minor) or legal guardinary. This STANDARD Based on observative review, the facility's (HRC) failed to enable all guardian for the consensus of the consen | is not met as evidenced by: ion, interview and record is Human Rights Committee sure written informed consent from the client and/or their the use of behavior support the four clients (Client #3) inple.                                                                                                                                                                                                                                                              |                          |                                                                                                        |                               |                            |  |
|                                                                                                     | Observation of the administration on 7:15 PM revealed including Seroquel Hydrochloride 50 r medication nurse administration revemedications were behaviors.  Review of Client # at 12:39 PM reveal Support Plan (BSF) The plan documer included 1:1 staffithe use of psychologeroguel). It should the seroquel is the seroguel of the plan documer included 1:1 staffithe use of psychologeroguel.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | evening medication April 2, 2008 at approximately Client #3 received medications I FC 400 mg and Naltrexone mg. Interview with the during the medication ealed the aforementioned used to address the client's  3's record on on April 4, 2008 aled the client had a Behavior by dated November 26, 2007. Inted restrictive techniques that mg supports, touch control and dropic medications (Revia and ald be noted that interview with Manager (HM) on April 2, 2008 |                          |                                                                                                        |                               |                            |  |

· DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/25/2008 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

|                          | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |         |      |                                   |          |         |       |      |                            |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | B. WING             | ·       |      |                                   |          |         |       | 04/0 | 4/2008                     |
| NAME OF P                | ROMDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | 3815 AL | LBER | SS, CITY, S<br>MARLE S<br>ON, DC  | TREET N  |         |       |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG |         | (EAC | ROVIDER'S<br>CH CORRE<br>S-REFERE | CTIVE AC | TION SI | HOULD | ΒE   | (X5)<br>COMPLETION<br>DATE |
| W 263                    | at 9:40 AM revealed the capacity to give of medications and former HM's statem 2008 at 12:39 PM to psychological assert Additionally, continued the management of the survey, the facility fits Human Rights Conformed consent formed c | d that Client #3 did not have informed consent for the use habilitation services. The nent was verified on April 4, hrough review of Client #3's sament dated July 9, 2007. Led interview with the former 3 revealed that Client #3 did ardian. At the time of the ailed to provide evidence that committee had obtained written or the use of Client #3's lan from a legally authorized as also W124] IGMT OF INAPPROPRIATE R  EVERT THE MARPEROPRIATE R  EVERY THE | W 2                 |         | ss r | eferen                            | ce Wl    | 24      |       |      | 5/14/08                    |
|                          | The finding include                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |         |      |                                   |          |         | ,     |      |                            |

|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | AND HUMAN SERVICES  & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                   | ,                 |                                                                                                         | OMB NO. 0                  | PROVED 938-0391            |  |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------|---------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CUA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1                 | IULTIPI<br>ILDING | LE CONSTRUCTION                                                                                         | (X3) DATE SURVEY COMPLETED |                            |  |
| ,                        | :                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. Wil            | NG                |                                                                                                         | 04/04/2008                 |                            |  |
| NAME OF PI               | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |                   | ET ADDRESS, CITY, STATE, ZIP CODE<br>15 ALBERMARLE STREET NW                                            |                            |                            |  |
| CMS                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                   |                   | ASHINGTON, DC 20008                                                                                     |                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREF<br>TAC |                   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPL<br>DEFICIENCY) | OULD BE   -                | (X5)<br>COMPLETION<br>DATE |  |
| W 278                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | age 34                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | W                 | 278               | <del></del>                                                                                             |                            |                            |  |
|                          | physician's order (of documented the cli Seroquel from 100 Seroquel 200 mg mg twice daily. Corecord on April 3, 2 another written phy 11, 2007. The ord was prescribed to day. Interview with (LPN) on April 3, 2 client's medication increase in exhibite (Cross Refer W24 House Manager (Happroximately 9:40 received 1:1 super The former HM fur received the 1:1 st day program. The implemented to as maladaptive behavand self injurious statement was ver April 2, 2008 and Interview with the Professional (QMI records on April 4, client had a Behav November 26, 200 | dated July 12, 2007) that lent was to increase his mg every morning and every evening to Seroquel 300 intinued review of the client's 2008, at 5:40 PM revealed visician's order dated October er documented that the client start Seroquel 400 mg twice a in the Licensed Practical Nurse 2008 at 9:25 AM verified that the had been increased due to an ed behaviors.  9) Interview with the former and behaviors.  9) Interview with the former and behaviors.  10) AM revealed that Client #3 vision for eight (8) hours daily ther revealed that Client #3 vision for eight (8) hours daily ther sepecial staffing support was esist Client #3 with addressing viors of elopement, aggression behaviors. The former HM's iffied through observation on |                   |                   |                                                                                                         |                            |                            |  |
|                          | non-compliance, p<br>spitting, hoarding,<br>fiddling, touching<br>Continued review<br>entitled. "Need for                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | theriging behaviors of onlying, onlying, masturbation, repetitive others and pulling his hair of the plan revealed a section 1:1 Staffing." According to that documented that "Client #3 is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | -                 |                   |                                                                                                         |                            |                            |  |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                         | A BUILDIN                                                                                                                                                                                                                                                                                                                                             | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED                                                                       |          |                            |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------|----------|----------------------------|
|                                                                                                      | . ,                                                                                                                                                                                                     | 09G037                                                                                                                                                                                                                                                                                                                                                | B. WING             |                                                                                                     | 04/04    | 1/2008                     |
| NAME OF P                                                                                            | ROVIDER OR SUPPLIER                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                       | 3                   | EET ADDRESS, CITY, STATE, ZIP CODE<br>815 ALBERMARLE STREET NW<br>VASHINGTON, DC 20008              |          |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                             | (EACH DEFICIENCY                                                                                                                                                                                        | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| W 278                                                                                                | Continued From pa                                                                                                                                                                                       | ge 35<br>o himself and/or others                                                                                                                                                                                                                                                                                                                      | W 278               | Cross reference W249                                                                                |          | 5/14/08                    |
|                                                                                                      | without a 1:1 staff p<br>psychiatric Axis I: Ir<br>his behaviors are u<br>weekends, upstairs<br>anywhere at anytim                                                                                      | erson at all times. He has a mpulse Control Disorder and inpredictable day, night, downstairs, on the van and e [Client #3] does much                                                                                                                                                                                                                 |                     |                                                                                                     |          |                            |
|                                                                                                      | immediately next to<br>the aforementioned<br>only in the BSP dat                                                                                                                                        | iar staff person is next to him, him." It should be noted that information was found not ed November 26, 2007 but previous BSP's dated February st 9, 2007.                                                                                                                                                                                           |                     |                                                                                                     |          |                            |
|                                                                                                      | 2, 2008 revealed the approved by the Me Administration (MA Client #3 with 1:1 s and therefore, the sonot been implement the survey, the facithat prior to the use technique, a less reimplemented and p | with the former HM on April at the facility had not been edicald Assistance A) for the cost of providing taffing supports at all times special staffing supports had ted as outlined. At the time of lity failed to provide evidence of a more restrictive estrictive technique had been proven to be ineffective in order 3's challenging behaviors. |                     |                                                                                                     |          |                            |
| W 322                                                                                                | (See also W249)                                                                                                                                                                                         | SICIAN SERVICES                                                                                                                                                                                                                                                                                                                                       | W 322               |                                                                                                     |          |                            |
|                                                                                                      | The facility must pr<br>general medical ca                                                                                                                                                              | ovide or obtain preventive and re.                                                                                                                                                                                                                                                                                                                    |                     |                                                                                                     |          |                            |
|                                                                                                      | Based on interview failed to ensure get                                                                                                                                                                 | is not met as evidenced by:<br>and record review, the facility<br>neral and preventative care<br>the four clients (Clients #2<br>the sample.                                                                                                                                                                                                          |                     |                                                                                                     |          |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIF         | PLE CONSTRUCTION                                                                              | (X3) DATE S<br>COMPLE |                            |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | B. WING             | <u> </u>                                                                                      | 04/0                  | 4/2008                     |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 38                  | EET ADDRESS, CITY, STATE, ZIP COI<br>M5 ALBERMARLE STREET NW<br>(ASHINGTON, DC 20008          | DE                    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE             | (X5)<br>COMPLETION<br>DATE |
| W 322                    | facility on April 2, 2 client was sucking revealed the client's both of his thumbs thumb appeared to Interview with the f6:42 PM revealed to on both thumbs that the client's continuous Additionally, the for client thumbs were Review of Client #4 2008 at 5:17 reveal dermatologist on Judermatologist on Judermatological condiagnosed with chrithumbs that was seand behavioral nail prescribed Triamcion the client's thum Additionally, the de Castellani Paint to the client from such review of the consudermatologist docu Paint "would not in the problem is caustaste of the Castell sucking and be the properties." It shouthen urse verified the was a behavior and the thumb sucking | Client #4 at the residential 1008, at 5:14 PM revealed the his thumb. Closer observation of fingernails were missing on The exposed area on each be discolored (brownish pink). The exposed area on each be discolored (brownish pink). The thuse Manager (HM) at that the client had an infection of the would not heal because of the stumb sucking behavior. The mer HM revealed that the being treated for an infection. It is medical record on April 4, the client was seen by the sultation form, the client was onic paronychia affecting both becondary to his thumb sucking trauma. The dermatologist moloone Cream to be applied abs twice daily for three weeks matologist recommended be applied once daily to deterking his thumbs. Continued altation form revealed that the mented that the Castellani tiate systemic antifungals as sed by a behavior. The foul ani Paint will deter thumb rapeutic due to antifungal all de noted that interview with that Client #4's thumb sucking this nails would not heal until ceased. At the time of the | W 322               |                                                                                               |                       |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ailed to provide evidence that<br>g provided to effectively treat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                               | ·                     |                            |

PRINTED: 04/25/2008

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 04/04/2008 09G037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3815 ALBERMARLE STREET NW CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Client #2 is scheduled to follow-W 322 W 322 Continued From page 37 up with audiologist on 5/15/08. Client #4's thumbs. (See also W214) The primary nurse and the QMRP 2. Review of Client #2's record on April 4, 2008 will meet monthly to review and at 7:04 PM revealed the client was seen by an audiologist. Review of the consultation form ensure that medical appointments revealed the client was recommended to return are scheduled on a timely manner. 5/15/08 after his ears were cleared. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 7:10 PM to ascertain if the client had returned for the audiological revisit and/or find out if the revisit was scheduled. At the time of the survey, the facility failed to provide evidence that Client #2 was seen for a follow up audiological visit. W 325 482.460(a)(3)(iii) PHYSICIAN SERVICES W 325 The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure routine laboratory studies were conducted, for one of the four clients (Client #1) included in the sample. The finding includes: Client #1's LFT and HgbAlC was Review of Client #1's April 2008 Physician's done on 4/24/08. The primary Orders on April 3, 2008 at 4:47 PM revealed nurserwiFL-be responsible for orders that documented the client receive laboratory tests including HBA1C every 3 months scheduling bloodwork per physician and a Liver Function Test (LFT) every 6 month. 4/24/08 order. Interview with the nurse via telephone on April 4, 2008 and continued review of Client #1's record

failed to provide evidence that the

aforementioned recommended tests were

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                |                                                                                                                                                                                                                                                                    | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION                                                                                        | (X3) DATE SU<br>COMPLE |                            |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------|------------------------|----------------------------|
|                          | 1                                                                                                                                                                                                                                                                                   | 09G037                                                                                                                                                                                                                                                             | B. WING _                | · · · · · · · · · · · · · · · · · · ·                                                                   | 04/04                  | 1/2008                     |
| NAME OF F                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                    | STF<br>3                 |                                                                                                         | -                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                    | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                        | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)    | OULD BE                | (X5)<br>COMPLETION<br>DATE |
| W 325                    | Continued From pa<br>conducted as order                                                                                                                                                                                                                                             | ed.                                                                                                                                                                                                                                                                | W 325                    |                                                                                                         |                        |                            |
|                          | 2. Review of Client #1's record on April 4, 2008 at 2:19 PM revealed the client had a urinalysis on October 23, 2007. Further review of the urinalysis results revealed the primary care physician signed the test and wrote a note indicating a urine culture and sensitivity test |                                                                                                                                                                                                                                                                    |                          | Client #1's urine spec<br>be collected. The prima<br>will ensure specimen is<br>and sent to the laborat | ry nurse<br>collected  | a<br>5/16/08               |
|                          | should be done. In<br>the Qualified Menta<br>(QMRP) on April 4,<br>culture and sensitiv<br>the time of the surv<br>evidence that the un<br>had been complete                                                                                                                        | terview was conducted with all Retardation Professional 2008 to ascertain if the urine ity had been completed. At ey, the facility failed to provide rine culture and sensitivity test d.                                                                          | ·                        |                                                                                                         |                        |                            |
| W 331                    |                                                                                                                                                                                                                                                                                     | NG SERVICES  ovide clients with nursing nce with their needs.                                                                                                                                                                                                      | W 331                    |                                                                                                         |                        |                            |
|                          | Based on interview facility's nursing ser each client received accordance with the clients (Clients #1)                                                                                                                                                                             | s not met as evidenced by: and record review, the vices failed to ensure that I nursing services in eir needs, for one of the four included in the sample.                                                                                                         |                          |                                                                                                         | :                      |                            |
|                          | day program on Ap-<br>did not receive his re-<br>prescribed dietary of<br>beverages). Reviet<br>April 4, 2008, at ap-<br>a speech and languet<br>1, 2007. According                                                                                                                 | Observation at Client #1's ril 4, 2008 revealed the client meal in accordance with his order (pureed with thickened w of Client #1's records on proximately 7:35 PM revealed lage evaluation dated August to the assessment, "Client aspiration of thin liquids. A |                          |                                                                                                         |                        |                            |

To: HRA

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT                 | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                 | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION                                                                                      | (X3) DATE SURY<br>COMPLETE |                            |
|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
|                           |                                                                                                                                                                               | 09G037                                                                                                                                                                                                                                | B. WING                  |                                                                                                       | 04/04/2                    | 2008                       |
| NAME OF P                 | ROVIDER OR SUPPLIER                                                                                                                                                           |                                                                                                                                                                                                                                       | 3                        | REET ADDRESS, CITY, STATE, ZIP CODE<br>815 ALBERMARLE STREET NW<br>VASHINGTON, DC 20008               |                            |                            |
| (X4) ID<br>PREFIX<br>TAG. | (EACH DEFICIENC)                                                                                                                                                              | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                       | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) |                            | (X5)<br>COMPLETION<br>DATE |
| W 331                     | conducted in May 2<br>Center. A moderate                                                                                                                                      | wallow study was last<br>2001 at Washington Hospital<br>te to severe oral phase of                                                                                                                                                    | W 331                    | Client #1's Health Mana<br>Care Plan will be updat<br>include the risk for as                         | ed to                      | 5/16/08                    |
|                           | were noted to occur<br>Continued review of<br>recommendation to<br>supervision at mea                                                                                         | ted. Coughing and choking ir after swallow initiation." of the assessment revealed a nat documented , "one to one litimes is needed." The ocumented that Client #1                                                                    |                          |                                                                                                       |                            |                            |
|                           | tolerated a "blende<br>thickened liquids (p<br>further described h                                                                                                            | rized pureed diet with<br>oudding consistency)." It<br>is eating at mealtimes and<br>ad "the tendency to shovel his                                                                                                                   |                          |                                                                                                       |                            | ٠.                         |
| W 368                     | Plan dated July 7,<br>PM revealed sever<br>areas/conditions.<br>failed to indicate at<br>client being at risk<br>care plan failed to<br>management proc<br>Client #1 during m | I's Health Management Care 2007 on April 3, 2008 at 6;23 ral documented risk Further review of the care plan by information regarding the for aspiration. Additionally, the document any risk redures to be utilized to assist reals. | W 368                    | 3                                                                                                     |                            | ·                          |
|                           | that all drugs are a<br>the physician's ord                                                                                                                                   |                                                                                                                                                                                                                                       |                          |                                                                                                       | -                          |                            |
|                           | Based on interview failed to ensure the administered in co                                                                                                                    | is not met as evidenced by: v and record review, the facility at medications were mpliance with the physician's four clients (Client #3) included                                                                                     |                          |                                                                                                       |                            |                            |
|                           | The finding include                                                                                                                                                           | es:<br>                                                                                                                                                                                                                               | <u></u>                  |                                                                                                       |                            |                            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| W 368 Continued From page 40  W 368 Continued From page 40  W 368 Continued From page 40  Review of Client #3's medical record on April 3, 2008 beginning at 5:30 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | JLTIP<br>DING | LE CONSTRUCTION                                                                                     | (X3) DATE SURVEY<br>COMPLETED                |                            |
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| CM S  SUMMARY STATEMENT OF DEPICIENCIES (ACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)  W 368 Continued From page 40  W 368 Continued From page 40  Review of Client #3's medical record on April 3, 2008 beginning at 5:30 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was prescribed Vitamin E Softgel 400 Unit Capsules twice daily for nutritional supplement. At 5:44 PM, review of the Client shedication Administration Record (MAR) revealed the Vitamin E was not administered because it was 'not available."  Interview was conducted with the facility's Registered Nurse to ascertain information regarding why the resident did not get the medication. The RN indicated that she could not remember why the medication was not administered because it was 'not available."  Interview as conducted with the facility's Registered Nurse to ascertain information regarding why the resident did not get the medication. The RN indicated that she could not remember why the medication was available. At the time of the survey, the facility failed to provide evidence that the medication prescribed by the physician for Client #3 was consistently given in compliance with the physician's orders.  W 440  The facility must hold evacuation drills at least |        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | B. WING |               |                                                                                                     | 04/04                                        | 1/2008                     |
| W 368  Continued From page 40  Review of Client #3's medical record on April 3, 2008 beginning at 5:30 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was prescribed Vitamin E Softgel 400 Unit Capsules twice daily for nutritional supplement. At 5:44 PM, review of the client's Medication Administration Record (MAR) revealed the Vitamin E was not administered because it was "not available."  Interview was conducted with the facility's Registered Nurse to ascertain information regarding why the resident did not get the medication. The RN indicated that she could not remember why the medication was available. At the time of the survey, the facility falled to provide evidence that the medication prescribed by the physician for Client #3 was consistently given in compliance with the physician's orders.  W 440  The facility must hold evacuation drills at least                                                                                                                                                                                                                                                                                                                                                                                       |        | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | 38            | 15 ALBERMARLE STREET NW                                                                             |                                              |                            |
| Review of Client #3's medical record on April 3, 2008 beginning at 5:30 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was prescribed Vitamin E Softgel 400 Unit Capsules twice daily for nutritional supplement. At 5:44 PM, review of the client's Medication Administration Record (MAR) revealed the Vitamin E was not administered from August 16, 2007, through August 23, 2007. Continued review of the MAR (on the back side) revealed on that the Vitamin E had not been administered because it was "not available."  Interview was conducted with the facility's Registered Nurse to ascertain information regarding why the resident did not get the medication. The RN indicated that she could not remember why the medication was not administered. She further revealed that the Vitamin E was purchased over- the - counter and it was the responsibility of the primary nurse to make certain the medication was available. At the time of the survey, the facility failed to provide evidence that the medication prescribed by the physician for Client #3 was consistently given in compliance with the physician's orders.  W 440  The facility must hold evacuation drills at least                                                                             | PREFIX | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PREFU   | ×             | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI                                         | ULD BE                                       | (X5)<br>COMPLETION<br>DATE |
| This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        | Review of Client #3 2008 beginning at 8 Order (POS) dated of the POS reveale prescribed Vitamin twice daily for nutrit PM, review of the condition of the Surveying of the Surveying of the Condition of the Condi | I's medical record on April 3, 5:30 PM revealed a Physician's March 2008. Further review d that the client was E Softgel 400 Unit Capsules ional supplement. At 5:44 lient's Medication ord (MAR) revealed the administered from August 16, ust 23, 2007. Continued (on the back side) revealed on ad not been administered to available."  Indicated with the facility's of ascertain information resident did not get the N indicated that she could not medication was not further revealed that the chased over- the - counter and bility of the primary nurse to nedication was available. At vey, the facility failed to provide the edication prescribed by the standard was consistently given in the physician's orders. CUATION DRILLS ald evacuation drills at least shift of personnel. |         |               | dispensed from the pharmal his other medications of basis. The primary nurs ensure that all medicat | macy with<br>n a month<br>e will<br>ions are |                            |

PRINTED: 04/25/2008

To: HRA

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 04/04/2008 09G037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3815 ALBERMARLE STREET NW. CMS WASHINGTON, DC 20008 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ΙD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 440 W 440 Continued From page 41 In the future, the facility will The finding includes: conduct a fire drill quarterly Interview with the House Manager on April 2, during each shift. The QMRP and 2008 at 1:10 PM revealed the direct care staff Residential Manager will review were assigned the following shifts of duty: fire drill records quarterly and 6/20/08 provide training on fire safety. Weekends/Weekdays 8:00 AM - 4:00 PM 4:00 PM - 12:00 AM 12:00 AM - 8:00 AM Weekends for 1:1 staff 8:00 AM - 8:00 PM 8:00 PM - 8:00 AM Review of the fire drill records on April 2, 2008, revealed that there was only one fire drill conducted on the 8:00 AM - 4:00 PM shift (March 4, 2008) for the entire year. At the time of the

each shift of personnel.

survey, the facility failed to provide evidence that evacuation drills were conducted quarterly for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NU |                                                                                    |                                                                                                                                             | (X2) MULTIP<br>A. BUILDING<br>B. WING                 | LE CONSTRUCTION          | COMPLE                                                                                     |           |                          |
|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------|-----------|--------------------------|
| ·                                                                                         | · · · · · · · · · · · · · · · · · · ·                                              | 09G037                                                                                                                                      | PTDGET ADT                                            |                          | TATE, ZIP CODE                                                                             |           | 12000                    |
| NAME OF P                                                                                 | ROVIDER OR SUPPLIER                                                                |                                                                                                                                             | 3815 ALBI                                             | ERMARLE S'<br>TON, DC 20 | TREET NW                                                                                   | _         |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                  | /EACH DEFICIENC                                                                    | ATEMENT OF DEFICIENC!<br>Y MUST BE PRECEDED B'<br>LSC IDENTIFYING INFORM                                                                    | Y FULL I                                              | ID<br>PREFIX<br>TAG      | PROVIDERS PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| ľ <b>00</b> 0                                                                             | INITIAL COMMEN                                                                     | ITS                                                                                                                                         |                                                       | 1 000                    |                                                                                            |           |                          |
|                                                                                           | from April 2, 2008<br>random sample of<br>from a residential<br>mental retardation | sure survey was cond<br>through April 4 200<br>four residents was s<br>population of seven<br>and other disabilitie                         | 8. A<br>selected<br>males with<br>s. The              |                          |                                                                                            |           |                          |
| • ;                                                                                       | the group home a                                                                   | ere based on observand at four day progra<br>eview of records, inc<br>eports.                                                               | ams,                                                  |                          |                                                                                            |           |                          |
| 1.047                                                                                     | 3502.5 MEAL SE                                                                     | RVICE / DINING ARI                                                                                                                          | EAS                                                   | 1047                     | . •                                                                                        |           |                          |
|                                                                                           | that meals, which GHMRP, are suite                                                 | all be responsible for<br>are served away fro<br>ed to the dietary need<br>ated in the Individual                                           | m the<br>ds of                                        |                          |                                                                                            |           | -                        |
|                                                                                           | Based on observative review, the GHMF served away from residents dietary           | ot met as evidenced<br>ation, interview and r<br>RP failed to ensure th<br>the GHMRP suited<br>needs, for one of fou<br>uded in the sample. | ecord<br>nat meals<br>the                             |                          |                                                                                            |           |                          |
|                                                                                           | The finding include                                                                | les:                                                                                                                                        |                                                       | ,                        |                                                                                            | .•        |                          |
|                                                                                           | provided Residen                                                                   | to ensure the day p<br>t #1 with meals that<br>dance with his preso                                                                         | were                                                  |                          |                                                                                            |           |                          |
| Health Roff                                                                               | April 2, 2008 at a interview revealed sticks, creamed cand peaches. Re             | e dinner meal on the pproximately 5:47 Pld Resident #1 was scorn, collard greens, esident #1's meal was were thickened.                     | M and staff<br>erved fish<br>milk, water<br>as pureed |                          | 6) 4-                                                                                      |           | (X6) DATE                |

LABORATORY DIRECTOR'S DE PROVIDER'S UPPNER REPRESENTATIVES SIGNATURE

5-9-0

|                          | OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                      | A. BUILDING                                       | LE CONSTRUCTION                                                                             | COMPLE    |                          |  |  |  |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | B. WING                                           |                                                                                             | 04/04     | 1/2008                   |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 030007                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADD                                                                                                                           | RESS, CITY, ST                                    | TATE, ZIP CODE                                                                              |           |                          |  |  |  |
| CMS                      | KOVIDER OR OGI F ELE.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3815 ALBE<br>WASHING                                                                                                                 | 3815 ALBERMARLE STREET NW<br>WASHINGTON, DC 20008 |                                                                                             |           |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | /EACH DESIGNENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | FULL !                                                                                                                               | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |  |  |  |
| 1 047                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | age 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | 1047                                              |                                                                                             |           |                          |  |  |  |
| 1047                     | member was further to the client during that the resident was edentulous. Review Physician's Orders revealed he was plow cholesterol purble added to his lique of the client seated a with his peers. Clauster was eating greens and cheese, juice however that Res                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | er observed to be situation meal. It should be as also observed to be as also observed at a table in a room experience of the astaff revealed the and milk. It should be also observation and am staff revealed the and milk. It should be also observed to be al | e noted pe pril 2008 :47 PM um, low fat, er was to ram on M revealed ating lunch I interview e resident macaroni pe noted vas cut up |                                                   |                                                                                             |           |                          |  |  |  |
|                          | and the prepared and served withoutheir form and/or of Resident #1's diet observation reveathe dining room by Day program staff continuously by his                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ces; the macaroni an collard greens were to the any special modific consistency as requirary order. Continued led that staff were prut intermittently left to was not observed to side during the lunt #1 was eating his                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | portioned cations to ed by diresent in the room. to be ch.                                                                           |                                                   |                                                                                             |           |                          |  |  |  |
|                          | day program staff if she was aware aware that the rescorrect textured dacknowledged the pureed diet with to intervene with the provide the client. Due to the staff mobserved food textures asked who was asked who | monitoring the meal of the client's dietary sident had not receiv iet. The staff persor e client's dietary orde hickened beverages, the served meal in or with the correct text nembers failure to ack ture concern, the start he day program.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | I was asked order and ed the as a set of the as a set of the area and area diet. It is a set of the aff member reparing the          |                                                   |                                                                                             |           |                          |  |  |  |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                               | A. BUILDING           | PLE CONSTRUCTION                                                                          | (X3) DATE SURVEY<br>COMPLETED |
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|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                                                                                                                                                                          |                                                                                                                               | B, WING               |                                                                                           | 04/04/2008                    |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                 |                                                                                                                               |                       | STATE, ZIP CODE                                                                           |                               |
| CMS                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                 | 3815 ALBE<br>WASHINGT                                                                                                         | RMARLE S<br>ON, DC 20 | STREET NW<br>0008                                                                         | <u> </u>                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SCIDENTIFYING INFORMA                                                                                                                                                                                                                                                               | FULL                                                                                                                          | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | OULD BE COMPLETE              |
| 1 047                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ige 2                                                                                                                                                                                                                                                                                                                           |                                                                                                                               | 1 047                 | Cross reference W120                                                                      | 5/5/08                        |
|                          | another staff members further indicated the was in the kitchen.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | at it was the responsioner at the day programat the responsible states                                                                                                                                                                                                                                                          | m and<br>aff person                                                                                                           |                       |                                                                                           |                               |
|                          | responsible for pre<br>April 4, 2008 at 11:<br>aware of Resident<br>According to that s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | lucted with the staff p<br>paring Resident #1's<br>52 AM to ascertain if<br>#1's prescribed dieta<br>taff person Resident                                                                                                                                                                                                       | meal on she was ary order. #1's meal                                                                                          |                       |                                                                                           |                               |
|                          | further revealed a chitchen, that indicate a No Added Salt (No pureed diet with the staff member was the meal that was                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | or chopped. The staft<br>document, located in<br>ted Resident #1 was<br>NAS), low fat, low cho<br>ickened liquids. Who<br>informed of the cons<br>served to Resident #<br>eat it in the manner in                                                                                                                               | the<br>to receive<br>blesterol<br>en the<br>istency of<br>1, she                                                              |                       |                                                                                           |                               |
|                          | nurse on April 4, 2 Resident #1 was to being at risk for as informed that Resi as prescribed, she resident from eatir person to prepare accordance with hithe time of the sur the day program paccordance with him the time with the time of the sur the day program paccordance with him the time of the sur the day program paccordance with him the time of the sur the day program paccordance with him the time of the sur the day program paccordance with him the time of the sur the s | ducted with the day p<br>008 at 12:04 PM that<br>be have a pureed diet<br>piration. When the red<br>dent #1's meal was re-<br>immediately stopped<br>and told the kitches<br>another meal for him<br>is dietary order (pure<br>vey, the facility failed<br>rovided Resident #1'<br>is prescribed dietary<br>Deficiency Report C | t revealed<br>due to<br>nurse was<br>not served<br>d the<br>in staff<br>n in<br>ted). At<br>to ensure<br>is meal in<br>order. |                       |                                                                                           |                               |
| l 135                    | W127)<br>3505.5 FIRE SAFI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | •                                                                                                                                                                                                                                                                                                                               |                                                                                                                               | l 135                 |                                                                                           |                               |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | all conduct simulated<br>fectiveness of the pl<br>ar for each shift.                                                                                                                                                                                                                                                            |                                                                                                                               | -<br>                 |                                                                                           | -                             |

|                          |                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                         | (X2) MULT<br>A BUILDII<br>B. WING | TPLE CONSTRUCTION  NG                                                                       | COMPLETED   |                          |  |
|--------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------------|-------------|--------------------------|--|
| NAME OF P                | ROVIDER OR SUPPLIER                                                                   | 09G037 STREET A                                                                                                                                                                            | DDRESS, CITY, STATE, ZIP CODE     |                                                                                             |             |                          |  |
| CMS                      |                                                                                       | 3815 AL<br>WASHIN                                                                                                                                                                          | BERMARLE<br>GTON, DC 2            |                                                                                             |             |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                       | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                                                                                     | ID<br>PREFIX<br>TAG               | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE . | (X5)<br>COMPLETE<br>DATE |  |
| l 135                    | Continued From p                                                                      | age 3                                                                                                                                                                                      | I 135                             | Cross reference W440                                                                        |             | 6/20/08                  |  |
| ·                        | Based on interview GHMRP failed to                                                    | t met as evidenced by:<br>v and record review, the<br>provide evidence that simulated<br>ducted at least four times a                                                                      | t I                               |                                                                                             |             |                          |  |
|                          | The finding include                                                                   | es:                                                                                                                                                                                        |                                   |                                                                                             |             |                          |  |
|                          | 2008 at 1:10 PM r                                                                     | House Manager on April 2,<br>evealed the direct care staff<br>following shifts of duty:                                                                                                    |                                   |                                                                                             |             |                          |  |
| ٠                        | Weekends/Weeke<br>8:00 AM - 4:00 PN<br>4:00 PM - 12:00 A<br>12:00 AM - 8:00 A         | 1<br>M                                                                                                                                                                                     |                                   |                                                                                             | ·           |                          |  |
|                          | Weekends for 1:1<br>8:00 AM - 8:00 PM<br>8:00 PM - 8:00 AM                            | л ·                                                                                                                                                                                        |                                   |                                                                                             |             |                          |  |
|                          | revealed that then<br>conducted on the<br>4, 2008) for the er<br>survey, the facility | drill records on April 2, 2008, e was only one fire drill 8:00 AM - 4:00 PM shift (Marchitire year. At the time of the failed to provide evidence that were conducted quarterly for onnel. |                                   |                                                                                             |             |                          |  |
|                          | (See also Federal<br>W440)                                                            | Deficiency Report Citation                                                                                                                                                                 |                                   | -                                                                                           |             | -                        |  |
| 1 161                    | 3507.2 POLICIES                                                                       | AND PROCEDURES                                                                                                                                                                             | l 161                             |                                                                                             |             |                          |  |
|                          |                                                                                       | be approved by the governing RP and shall be reviewed at                                                                                                                                   |                                   | In the future, the ensure that the pol cedure manual be re                                  | icy and pro | 1                        |  |
| lealth Regu              | lation Administration                                                                 | · · · · · · · · · · · · · · · · · · ·                                                                                                                                                      | 6899                              | QX2O11                                                                                      | If continua | ation sheet 4 of 2       |  |

#226 P. 048/065

PRINTED: 04/25/2008 FORM APPROVED

|                          | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:           |                                                                                                                                                                  |                                                         | A BUILDING          | =              | N<br>                                                                                        | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------|----------------|----------------------------------------------------------------------------------------------|-------------------------------|--------------------------|
|                          |                                                                                                             | 09G037                                                                                                                                                           |                                                         | B. WING_            |                |                                                                                              | 04/04                         | 2008                     |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                         |                                                                                                                                                                  |                                                         |                     | TATE, ZIP CODE |                                                                                              | •                             |                          |
| CMS                      |                                                                                                             |                                                                                                                                                                  | 3815 ALBE<br>WASHING                                    | RMARLE S            |                |                                                                                              | <del></del>                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)                                                                                            | TEMENT OF DEFICIENCIE:<br>YMUST BE PRECEDED BY<br>SCIDENTIFYING INFORMA                                                                                          | FULL,                                                   | ID<br>PREFIX<br>TAG | (EACH COR      | R'S PLAN OF CORRECTIVE ACTION SHO<br>RECTIVE ACTION SHO<br>RENCED TO THE APPI<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETE<br>DATE |
| l 161                    | Continued From pa                                                                                           | ige 4                                                                                                                                                            |                                                         | 1 161               | annually by    | the Program                                                                                  | Director                      | 5/23/08                  |
|                          | Based on interview<br>GHMRP failed to p                                                                     | met as evidenced by<br>and record review, to<br>rovide evidence that<br>riewed its policies and<br>ly.                                                           | he<br>its                                               |                     |                |                                                                                              |                               |                          |
| ٠,.                      | The finding includes:                                                                                       |                                                                                                                                                                  |                                                         |                     |                |                                                                                              | ·                             |                          |
|                          | review of the policy<br>April 2, 2008 at 3:4<br>that the governing<br>procedures annual<br>procedure manual | ormer House Manag<br>and procedure man<br>failed to provide even<br>body reviewed its po-<br>ily. According to the<br>the last date the governmental was on Nove | ual on<br>vidence<br>licies and<br>policy and<br>erning |                     |                |                                                                                              |                               |                          |
| I 180                    | 3508.1 ADMINIST                                                                                             | RATIVE SUPPORT                                                                                                                                                   | ·                                                       | i 180               |                |                                                                                              |                               | ·                        |
|                          | administrative sup                                                                                          | Il provide adequate<br>port to efficiently med<br>ents as required by the                                                                                        | et the<br>neir                                          |                     |                |                                                                                              |                               | -                        |
|                          | Based on observareview, the GHMR administrative sup efficiently meet the required by their h                | t met as evidenced be<br>tion, interview and resure ac<br>port had been provide<br>needs of the reside<br>abilitation plans, for the<br>sidents #1, #3, and #    | cord<br>lequate<br>ed to<br>nts as<br>hree of the       |                     |                |                                                                                              |                               |                          |
|                          | effectively trained                                                                                         | es:<br>ed to ensure staff we<br>to implement Client :<br>Plan. [See W194]                                                                                        |                                                         |                     | 1. Cross r     | eference W159                                                                                | ·                             | 5/23/08                  |
| Hoolth Dog               | Vation Administration                                                                                       | <del></del>                                                                                                                                                      |                                                         |                     |                |                                                                                              |                               |                          |

|                          | T OF DEFICIENCIES<br>OF CORRECTION                                                                                 | 1 2 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5                                                                                                                             |                                                        |                              | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |                                                             |                      | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------|----------------------------------------|---------|-------------------------------------------------------------|----------------------|-------------------------------|--------------------------|
|                          |                                                                                                                    | 00.0037                                                                                                                                                                 |                                                        | B. WING _                    |                                        |         |                                                             |                      | 04/0                          | 4/2008                   |
|                          |                                                                                                                    | 09G037                                                                                                                                                                  | STREET ADD                                             | DRESS, CITY, STATE, ZIP CODE |                                        |         |                                                             |                      |                               |                          |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                | s .                                                                                                                                                                     |                                                        | BERMARLE STREET NW           |                                        |         |                                                             |                      |                               |                          |
| CMS                      |                                                                                                                    |                                                                                                                                                                         | WASHING                                                | TON, DC 2                    | 8000                                   |         |                                                             |                      |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                   | TEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA                                                                                                | FULL [                                                 | ID<br>PREFIX<br>TAG          | C                                      | /EACH C | DER'S PLAN OF<br>ORRECTIVE ACT<br>FERENCED TO<br>DEFICIENCE | TON SHOU<br>THE APPR | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| I 180                    | Continued From pa                                                                                                  | nge 5                                                                                                                                                                   |                                                        | l 180                        |                                        |         | • -                                                         |                      |                               |                          |
| . !                      | 2. The QMRP faile functional assessm                                                                               | d to ensure a comprenent of behavioral nent #4. [See W214]                                                                                                              | eds was                                                |                              | 2. 0                                   | cross   | reference                                                   | w214                 |                               | 5/14/08                  |
| •                        | documented in the were stated separa                                                                               | ed to ensure objective<br>Individual Program bately, in terms of a si<br>e for Client #3. [See                                                                          | Plan (IPP)<br>ngle                                     |                              | 3. (                                   | Cross   | reference                                                   | W229                 |                               | 5/14/08                  |
|                          | received continuou                                                                                                 | ed to ensure that Clie<br>us active treatment s<br>entions. [See W249]                                                                                                  | ervices                                                |                              | 4. (                                   | Cross   | reference                                                   | W249                 |                               | 5/14/08                  |
| ,                        | use of more restric                                                                                                | ed to ensure that prictive techniques, the difference that programs inconiques had been atterseed W278]                                                                 | client's<br>orporating                                 |                              | 5.                                     | Cross   | reference                                                   | . W249               | •.                            | 5/14/08                  |
| ·                        | behavior support                                                                                                   | ed to ensure Client #<br>plan and correspond<br>ere effectively monit                                                                                                   | ing data                                               |                              | 6.                                     | Cross   | reference                                                   | ∍ W159               | #6                            | 5/23/08                  |
|                          | #3's records on Aj<br>revealed the clien<br>(BSP) dated Nove<br>documented that<br>behaviors of non-               | QMRP and review opril 4, 2008 at 12:39 thad a Behavior Supember 26, 2007. The Client #3 had challer compliance, physical spitting, hoarding etitive fiddling, touch ir. | PM pport Plan plan ging l                              |                              |                                        |         |                                                             |                      |                               |                          |
|                          | revealed intervent<br>redirection and to<br>Client #3 with his<br>According to the pure be used by staff versions. | of the BSP on Aprilition strategies (verbauch control) were us challenging behavious, verbal redirection whenever Client #3 wengaged in any one                         | al<br>ed to assist<br>rs.<br>on was to<br>vas about to |                              |                                        |         |                                                             | ·                    |                               |                          |

|                          | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                    | (X2) MULTIF<br>A. BUILDING<br>B. WING | PLE CONSTRUCTION                                                                                     | (X3) DATE SURVEY COMPLETED  04/04/2008 |                          |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------|
|                          | ·<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                    |                                       | THE CODE                                                                                             | 04/04                                  | 12008                    |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3815 ALBE                                                                                                                                                                                                                                                                                          |                                       |                                                                                                      |                                        |                          |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENC!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | FULL                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                                | (X5)<br>COMPLETE<br>DATE |
| J 180                    | that touch control verdirection did not was serious or imputhat touch control used "only if quick additionally documeresponsible for documeresponsible for documeresponsible for documeresponsible for documeresponsible for documeres of [Cliffrequencies of state behavioral data should be a control of the corresponsible for staff each behavior smonthly designed for staff each behavior occumentate of the control occasions where in utilized in accordant targeted behaviors.  a. May 7, 2007 (1) data collection for engaged in 1 incidents of pulling fiddling with object non-compliance, a masturbation. Restrategy documentate revealed that was the only interventaged in 1 incidents of pulling fiddling with object non-compliance, a masturbation. Restrategy documentate revealed that was the only interventaged in 1 incidents of pulling fiddling with object non-compliance, a masturbation. Restrategy documentate revealed that was the only interventaged in 1 incidents of pulling fiddling with object non-compliance, a masturbation. Restrategy documentate of the control of the data collection for the data collecti | The plan further incomes to be utilized if the work and only if the sortant. The plan care should be a last resortant action is required." ented that staff were currenting the "total ent #3's] behaviors a fintervention steps" eet.  esponding data cotte 008 at 10:32 AM revent #3 exhibited challed. The data collection to document the frequence and the intervention strategies are exhibited. For 2:00 AM to 8:00 AM m documented that the lent of hoarding item of the incomes of the intervention of the aforement one instance of tour vention utilized.  (12:00 AM to 8:00 AM on form documented and the intervention of the aforement one instance of tour vention utilized. | e verbal situation utioned ort" and The plan  The plan  Ind the on the  ction ealed enging form was puency that ention uch ew of the d several s were not BSP when r example: shift) - The Client #3 s, 2 of repetitive appropriate tion entioned ch control  M shift) - that Client fiddling with |                                       |                                                                                                      |                                        |                          |
|                          | objects, 1 inciden                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | t of spitting on peopl                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                    | _l                                    | <u> </u>                                                                                             | <del></del> .                          |                          |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G037                             |                                                                                                                                                                                                     |                                                                   | (X2) MULTI<br>A. BUILDIN<br>B. WING  | PLE CONSTRUCTION  G                                                                              | (X3) DATE SURVEY<br>COMPLETED<br>04/04/2008 |   |  |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------|---|--|
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                      |                                                                                                                                                                                                     | STREET ADD                                                        | DDRESS, CITY, STATE, ZIP CODE        |                                                                                                  |                                             |   |  |
| CMS                      |                                                                                                                                          |                                                                                                                                                                                                     | 3815 ALBI<br>WASHING                                              | BERMARLE STREET NW<br>GTON, DC 20008 |                                                                                                  |                                             |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                         | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA                                                                                                                                  | FULL                                                              | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE COMPLETE                           |   |  |
| I 180                    | Continued From page 7                                                                                                                    |                                                                                                                                                                                                     |                                                                   | I 180                                |                                                                                                  |                                             |   |  |
|                          | of the intervention :                                                                                                                    | opriate masturbation.<br>strategy documentati<br>te revealed no interv<br>olemented.                                                                                                                | ion for the                                                       |                                      |                                                                                                  |                                             |   |  |
|                          | The data collection #3 engaged in 3 in incidents of spitting inappropriate mast intervention strategaforementioned da                    | 12:00 AM to 8:00 AM form documented the cidents of pulling his gon people and 2 incurbation. Review of gy documentation for the revealed that touch only intervention ut                            | nat Client  <br>hair, 3<br>cidents of<br>the<br>the<br>ch control | . ,                                  |                                                                                                  |                                             |   |  |
|                          | The data collection #3 engaged in 1 in 3 incidents of inap Review of the interdocumentation for                                          | the aforementioned control (three times                                                                                                                                                             | hat Client<br>people and<br>on.<br>date                           |                                      |                                                                                                  |                                             | - |  |
| •                        | The data collection #3 engaged in 3 in and 3 incidents of Review of the intel documentation for                                          | 12:00 AM to 8:00 AM form documented to acidents of spitting or inappropriate masturivention strategy the aforementioned ention strategies were                                                      | hat Client<br>n people<br>rbation.<br>date                        |                                      |                                                                                                  |                                             |   |  |
|                          | data collection for<br>engaged in 3 incid<br>incidents of pulling<br>fiddling with object<br>non-compliance, 3<br>others and 3 incidents | 3:00 AM to 4:00 PM s<br>m documented that 0<br>lents of hoarding iter<br>g his hair, 1 incident of<br>ts, 4 incidents of<br>3 incidents of aggress<br>ents of elopement re<br>of the intervention s | Client #3<br>ms, 4<br>of repetitive<br>sion to<br>elated          |                                      |                                                                                                  |                                             | - |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            | (X2) MULTII<br>A. BUILDING<br>B. WING | PLE CONSTRUCTION                                                                            | (X3) DATE SU<br>COMPLET |                    |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------|-------------------------|--------------------|
|                                                                                                     |                                                                                           | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                            | DECO CITY S                           | STATE, ZIP CODE                                                                             |                         | 72008              |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                            | RMARLE S                              | STREET NW                                                                                   |                         | ÷.                 |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC)                                                                          | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FULL                                       | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE               | (X5) COMPLETE DATE |
| I 180                                                                                               | revealed no interve implemented.                                                          | the aforementioned on the control of | •                                          | l 180                                 |                                                                                             |                         |                    |
|                                                                                                     | The data collection #3 engaged in 1 inc<br>Review of the inter-<br>documentation for      | 12:00 AM to 8:00 AM form documented the cidents of hoarding it wention strategy the aforementioned ention strategies were                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | nat Client<br>iems.<br>date                |                                       |                                                                                             |                         |                    |
|                                                                                                     | data collection form<br>engaged in 3 incid<br>masturbation. Rev<br>documentation for      | 8:00 AM to 4:00 PM son documented that Clents of inappropriate view of the intervention the aforementioned ention strategies were                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | client #3<br>e<br>on strategy<br>date      |                                       |                                                                                             |                         |                    |
|                                                                                                     | The data collection #3 did not engage                                                     | 12:00 AM to 8:00 AM i form documented to in any of his targeted h control was used a gy twice.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | hat Client                                 |                                       |                                                                                             |                         |                    |
|                                                                                                     | The data collection #3 did not engaged people. Review of documentation for                | 12:00 AM to 8:00 AM to form documented to the second in 8 incidents of specific from the intervention strategies were the aforementioned ention strategies were                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | hat Client<br>itting on<br>ategy<br>date   |                                       |                                                                                             |                         | . ,                |
|                                                                                                     | provide evidence t<br>monitored Client #<br>collection and/or the<br>intervention strates | survey, the facility faith hat the QMRP effect 3's BSP to ensure the implementation of gies were completed the BSP. (See also                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | tively<br>nat the data<br>f<br>l/conducted | -                                     |                                                                                             |                         |                    |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G037  NAME OF PROVIDER OR SUPPLIER  STREET ALL  STREET ALL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                               |                                                                     | A. BUILDING<br>B. WING  |                                                                                                   | (X3) DATE SU<br>COMPLE<br>04/04 |                          |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------|---------------------------------|--------------------------|
| NAME OF P                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                               | 1                                                                   |                         | STATE, ZIP CODE                                                                                   |                                 |                          |
| CMS                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                               |                                                                     | ERMARLE S<br>TON, DC 20 |                                                                                                   |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM                                                                                                                         | FULL                                                                | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORE<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE                        | (X5)<br>COMPLETE<br>DATE |
| I 180                    | Deficiency Report Citation W159)  7. The facility's Governing Body failed to monitor and/or revise its operation directions to ensure the facility's environment was appropriate and provided for the health and safety as well as active treatment services for Client #1.  Observation at the residential facility on April 2, 2008 at approximately 4:41 PM revealed Client #1 entering the facility. The client required the assistance of two direct care staff (one on each side of the client) to ambulate to the recliner chair that was located in the living room. Interview with staff on April 2, 2008 at approximately 5:02 PM revealed that Client #1 required the support of at least two people to ascend the exterior front stairwell in order to enter the facility. Staff further revealed up the stairwell. |                                                                                                                                                                                               |                                                                     | l 180                   |                                                                                                   |                                 |                          |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                               |                                                                     |                         |                                                                                                   |                                 |                          |
|                          | 2008 at approxima<br>#1 entering the fact<br>three staff membe<br>behind, to the right<br>order to assist him<br>ambulating from the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | he residential facility ately 3:44 PM reveals ility with the assistar rs. The staff were pit, and in front of Clies into the facility. When the front entrance to the staff persons.          | ed Client<br>nce of<br>ositioned<br>nt #1 in<br>ille<br>he recliner |                         |                                                                                                   |                                 |                          |
|                          | Mental Retardation former House Mar 5:26 PM to ascert aforementioned coambulation into/ou According to the ir assessed to transi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ducted with the Qual<br>in Professional (QMR<br>nager (HM) on April 4<br>ain information about<br>oncern regarding Clie<br>at of and around the interview, Client #1 wittion to another resid | RP) and 4, 2008 at t the ent #1 ' s facility. as being ential       |                         |                                                                                                   |                                 |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                         | A BUILDIN                                                                                                               | PLE CONSTRUCTION    |                                                                                        | (X3) DATE SURVEY<br>COMPLETED  |                          |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------|--------------------------------|--------------------------|
|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                         | B. WING_            |                                                                                        | 04/04                          | 4/2008                   |
| NAME OF F                                                                    | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         |                     | STATE, ZIP CODE                                                                        |                                |                          |
|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         | TON, DC 2           | STREET NW<br>0008                                                                      |                                |                          |
| (X4) ID<br>PREFIX<br>TAG                                                     | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 180                                                                          | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ge 10                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 1180                |                                                                                        | . •                            |                          |
|                                                                              | that would include of barrier free environ acquiring a physica obtaining a neurolo cardiology evaluated to reconvene regard It should be further revealed that the fathe Department of I since 2006 regarding the facility. Continue HM revealed that simanager has changed elay in his transition former HM also revealed that simanager has changed elay in his transition former HM also revealed that simanager has changed elay in his transition former HM also revealed that simanager has changed elay in his transition former HM also revealed that the facility with the new functioning had declared that the facility of the faci | sciplinary team initial client #1 moving to a ment. The plan con I therapy assessment gical evaluation and on. The team further ding the matter in this noted that the forme cility had been meet Disability Services (Disability Services (Disability Services (Disability Services) and the change on into another home called that the client's reased with in the purse on April 3, 2008 and Client #1 needed ment. | more sisted of at, a agreed rty days r HM ing with DDS) ning out of a former case caused a b. The s ast year. 3 at 6:00 |                     |                                                                                        |                                |                          |
| 1 203                                                                        | 5:25 PM revealed a dated August 2, 20the assessment, the "locate a facility that placement." At the governing body failt regarding Client #1 adequately address barrier free living en Deficiency Report C 3509.3 PERSONNI Each supervisor she descriptions with each playment and at the state of the supervisor shades and supervisor shades are supervisor shades and at the supervisor at the supervisor and at the supervisor at th | EL POLICIES all discuss the conteach employee at the least annually there                                                                                                                                                                                                                                                                                                                                               | ment review of nended to for his the tter d been de a more so Federal ents of job beginning after.                      | l 203               |                                                                                        |                                |                          |
| Jealth Poqui                                                                 | This Statute is not ation Administration                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | met as evidenced b                                                                                                                                                                                                                                                                                                                                                                                                      | y:                                                                                                                      |                     |                                                                                        |                                |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                       |                                                                           | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION    | (X3) DATE SU<br>COMPLET                                                                              |           |                          |
|-----------------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------|--------------------------|---------------------|------------------------------------------------------------------------------------------------------|-----------|--------------------------|
| 09G037                                                                                              |                       |                                                                           | B. WING _                |                     | 04/04                                                                                                | /2008     |                          |
|                                                                                                     |                       |                                                                           | DRESS, CITY, S           | STATE, ZIP CODE     |                                                                                                      |           |                          |
| смѕ                                                                                                 |                       |                                                                           |                          | ERMARLE STON, DC 2  | STREET NW<br>0008                                                                                    |           | ,                        |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (EACH DEFICIENC)      | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA | FULL                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE   | (X5)<br>COMPLETE<br>DATE |
| 1 203                                                                                               | Continued From pa     | age 11                                                                    |                          | 1 203               | The facility will ensur                                                                              | e that al | 1                        |
| •                                                                                                   |                       | and record review, t                                                      | ho                       |                     | staff's job description                                                                              | • • •     |                          |
|                                                                                                     |                       | rovide evidence that                                                      |                          | ·                   | discussed and reviewed                                                                               |           | : .                      |
| ,                                                                                                   | supervisor discuss    | ed the contents of joi                                                    | 5                        |                     | In the future, Manageme                                                                              |           |                          |
| ,                                                                                                   | descriptions with ea  | ach employee at the                                                       | beginning                |                     | review employee files m                                                                              | onthly.   | 5/23/08                  |
|                                                                                                     | of their employmer    | nt and annually therea                                                    | atter.                   |                     |                                                                                                      |           |                          |
|                                                                                                     | The finding include   | es:                                                                       | -                        | <br>                |                                                                                                      |           |                          |
|                                                                                                     |                       |                                                                           | t                        |                     |                                                                                                      |           | ,                        |
|                                                                                                     | Interview with the f  | ormer House Manag<br>RP's personnel files                                 | er and<br>on April 2     | <b>1</b>            |                                                                                                      |           |                          |
|                                                                                                     |                       | revealed the GHMRF                                                        |                          |                     | • .                                                                                                  |           |                          |
|                                                                                                     | provide evidence th   | hat eight direct care s                                                   | staff had                |                     | -                                                                                                    |           |                          |
|                                                                                                     | the contents of the   | ir job descriptions dis                                                   | cussed                   | .]                  |                                                                                                      |           |                          |
|                                                                                                     |                       | eginning of their empl                                                    | loyment                  |                     |                                                                                                      | •         |                          |
|                                                                                                     | and/or annually the   | ereanter.                                                                 |                          |                     | 1                                                                                                    |           |                          |
| 1 206                                                                                               | 3509.6 PERSONN        | EL POLICIES                                                               |                          | 1206                | In the future, the fac                                                                               | ility wil | <u>†</u>                 |
| 1 200                                                                                               | 3309.0 F LINGOWN      | LET OLIGIES                                                               |                          | ,                   | ensuresthat all employe                                                                              |           |                          |
|                                                                                                     |                       | rior to employment ar                                                     |                          |                     | maintain a current heal                                                                              | th status |                          |
|                                                                                                     |                       | , shall provide a phys                                                    |                          |                     | In the future, Manageme                                                                              | nt will   |                          |
|                                                                                                     |                       | health inventory has<br>t the employee ' s he                             |                          |                     | review employee files m                                                                              | onthly.   | 5/23/08                  |
|                                                                                                     | would allow him or    | her to perform the re                                                     | ann status<br>equired    |                     |                                                                                                      |           |                          |
|                                                                                                     | duties.               | nor to periorn, are .                                                     |                          |                     |                                                                                                      |           |                          |
| ,                                                                                                   |                       | ·                                                                         |                          |                     |                                                                                                      |           |                          |
|                                                                                                     |                       |                                                                           | •                        |                     |                                                                                                      |           |                          |
|                                                                                                     |                       |                                                                           |                          |                     |                                                                                                      | •         |                          |
|                                                                                                     | This Statute is not   | t met as evidenced b                                                      | y:                       | 1                   |                                                                                                      |           |                          |
|                                                                                                     | Based on interview    | v and record review,                                                      | the                      |                     |                                                                                                      |           | ,                        |
|                                                                                                     | GHMRP failed to e     | ensure that each emp                                                      | oloyee,                  |                     |                                                                                                      |           |                          |
|                                                                                                     | prior to employme     | nt and annually there<br>of a physician's cert                            | aner,<br>fication        | 1                   |                                                                                                      |           |                          |
|                                                                                                     |                       | health inventory had                                                      |                          |                     |                                                                                                      |           |                          |
|                                                                                                     |                       | t the employee's hea                                                      |                          |                     |                                                                                                      |           |                          |
|                                                                                                     | would allow him or    | her to perform the r                                                      |                          |                     |                                                                                                      |           |                          |
|                                                                                                     | duties.               |                                                                           |                          |                     |                                                                                                      |           |                          |
|                                                                                                     | The finding include   | es:                                                                       |                          |                     |                                                                                                      |           |                          |
| Health Regu                                                                                         | lation Administration |                                                                           | ·                        | <del> </del>        | <u> </u>                                                                                             |           | <u> </u>                 |

#226 P. 056/065

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                    |                                                                                                                                                                            | (X2) MULTII<br>A. BUILDING                                |                         | TRUCTION |                                             | C          | (X3) DATE SURVEY COMPLETED |       |                          |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------|----------|---------------------------------------------|------------|----------------------------|-------|--------------------------|
|                                                                                                     |                                                                                                                                    | 09G037                                                                                                                                                                     |                                                           | B. WING_                |          |                                             |            | <u> </u>                   | 04/0  | 4/2008                   |
| NAME OF P                                                                                           | ROVIDER OR SUPPLIER                                                                                                                |                                                                                                                                                                            |                                                           | RESS, CITY, S           |          |                                             | -          |                            |       | _                        |
| CMS                                                                                                 |                                                                                                                                    |                                                                                                                                                                            | 3815 ALB<br>WASHING                                       | ERMARLE S<br>TON, DC 20 | 8000     |                                             |            |                            |       |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                            | /EACH DEFICIENCY                                                                                                                   | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SCIDENTIFYING INFORMA                                                                                                          | FULL                                                      | ID<br>PREFIX<br>TAG     | /F.¢     | PROVIDER'S<br>ACH CORREC<br>SS-REFEREN<br>D | TIVE ACTIO | N SHOUI<br>E APPRO         | LD BE | (X5)<br>COMPLETE<br>DATE |
| 1 206                                                                                               | Continued From pa                                                                                                                  | ge 12                                                                                                                                                                      |                                                           | 1 206                   |          | •                                           | •          |                            |       |                          |
|                                                                                                     | review of the GHMI<br>2008 at 12:00 PM r                                                                                           | ormer House Manag<br>RP's personnel files of<br>revealed the GHMRF<br>nat current health cer<br>r staff.                                                                   | on April 2,  <br>P failed to                              |                         |          |                                             |            |                            |       |                          |
| I 229                                                                                               | 3510.5(f) STAFF T                                                                                                                  | RAINING                                                                                                                                                                    | ,                                                         | 1229                    | Cross    | referen                                     | ce W159    | , W24                      | :9    | 5/23/08                  |
| -                                                                                                   | Each training progr<br>limited to, the follow                                                                                      | am shall include, buving:                                                                                                                                                  | t not be                                                  |                         |          |                                             | ٠          |                            |       |                          |
|                                                                                                     | residents to be ser                                                                                                                | related to the GHMR<br>ved including, but no<br>gement, sexuality, no<br>mmunications, and a                                                                               | t limited<br>itrition,                                    |                         |          |                                             |            |                            |       |                          |
|                                                                                                     | Based on observation review, the GHMR effectively trained documentation of support plan for on                                     | met as evidenced b<br>tion, interview and re<br>P failed to ensure sta<br>on the implementation<br>each resident's beha<br>he of the four resident<br>luded in the sample. | cord<br>aff were<br>on and<br>vior<br>its                 |                         |          |                                             | ·<br>·     |                            |       |                          |
|                                                                                                     | The finding include                                                                                                                | es:                                                                                                                                                                        |                                                           |                         |          |                                             |            |                            |       |                          |
|                                                                                                     | direct care staff we                                                                                                               | o provide evidence to<br>ere able to demonstr<br>implementation of C<br>Plan (BSP).                                                                                        | até                                                       |                         |          |                                             |            |                            |       |                          |
|                                                                                                     | PM revealed the c<br>room with a plastic<br>was observed to o<br>times. The client<br>index finger in the<br>across his lower line | ient #3 on April 2, 20<br>lient standing in the<br>cegg in his hand. The<br>pen and close the eq<br>was also observed in<br>egg then rubbing his<br>p on several occasion  | dining he client gg several nserting his s finger ons. It |                         |          |                                             |            |                            |       |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                     | A BUILDING                    | PLE CONSTRUCTION                                                                                        | (X3) DATE SUI<br>COMPLET | RVEY<br>ED               |  |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                          | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                     | B. WING_                      |                                                                                                         | 04/04                    | /2008                    |  |
| NAME OF P                                                                    | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADI                                                                                                                                                          | DDRESS, CITY, STATE, ZIP CODE |                                                                                                         |                          |                          |  |
| смѕ                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                     | ERMARLE S                     | <u></u>                                                                                                 |                          |                          |  |
| (X4) ID<br>PREFIX<br>TAG                                                     | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                         | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORMA                                                                                                                                                                                                                                                                                                                                                                           | FULL                                                                                                                                                                | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE                   | (X5)<br>COMPLETE<br>DATE |  |
| l 229                                                                        | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                        | age 13                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                     | 1229                          |                                                                                                         |                          |                          |  |
|                                                                              | was present and w                                                                                                                                                                                                                                                                                                                                                                                                        | itnessed the activity.                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                     |                               |                                                                                                         |                          |                          |  |
|                                                                              | Professional (QMR records on April 4, client had a BSP displan documented the challenging behavior the plan further do incorporated the usif necessary touch engaged in any of landitionally, the plastaffing supports at with addressing all During the aforement observed to introllent's fiddling. Further survey, Client #3 with staffing supports at the time of the survey staff were able to climplement Client # | Qualified Mental Retails) and review of Clie 2008 at 12:39 PM reated November 26, 2 hat Client #3 had severs including repetitive control whenever Client whenever Client and included the user of his targeted behaviour and included the user of his targeted behaventioned observation ervene and/or addresurthermore, throughoves not observed to het all times. (See alsovey, the facility failed demonstrate skills ness outlined. (See Fed.) | ent #3's vealed the too7. The veral ve fiddling. that on and/or ent #3 's. of 1:1 ne client viors , staff was ss the ut the nave 1:1 W249). At to ensure cessary to |                               |                                                                                                         |                          |                          |  |
| 1379                                                                         | Deficiency Report                                                                                                                                                                                                                                                                                                                                                                                                        | Citation W194)                                                                                                                                                                                                                                                                                                                                                                                                                                      | -                                                                                                                                                                   | 1 379                         |                                                                                                         | :                        |                          |  |
|                                                                              | In addition to the re<br>each GHMRP shal<br>Health, Health Fac<br>unusual incident or<br>interferes with a re<br>arrangement, well<br>places the residen-<br>be made by teleph<br>followed up by writ                                                                                                                                                                                                                    | eporting requirement Il notify the Departme cilities Division of any r event which substa esident 's health, wel being or in any other t at risk. Such notific none immediately and ten notification withir burs or the next work                                                                                                                                                                                                                   | ent of other other ntially fare, living way ation shall be n                                                                                                        | -                             |                                                                                                         |                          |                          |  |
| Health Beau                                                                  | lation Administration                                                                                                                                                                                                                                                                                                                                                                                                    | <del></del> -                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                     |                               | •                                                                                                       |                          |                          |  |

|                          | T OF DEFICIENCIES OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIE                                                                                                                                                       |                                                               | 1, ,                                 | FIPLE CONSTRUCTION                                                              | (X3) DATE S<br>COMPLE            |                          |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------|----------------------------------|--------------------------|--|
| •                        | ·                                                                                                              | 09G037                                                                                                                                                                      | •                                                             | A. BUILDI<br>B. WING                 | <del></del>                                                                     | 04/0                             | 4/2008                   |  |
| NAME OF P                | RÖVIDER OR SUPPLIER                                                                                            | 030037                                                                                                                                                                      | STREET ADD                                                    | DRESS, CITY,                         | STATE, ZIP CODE                                                                 |                                  |                          |  |
| CMS                      | NOVIDER OR OUT I ELEC                                                                                          | ,                                                                                                                                                                           | 3815 ALB                                                      | BERMARLE STREET NW<br>GTON, DC 20008 |                                                                                 |                                  |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORM                                                                                                   | FULL                                                          | ID<br>PREFIX<br>TAG                  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TON SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| l 379                    | Continued From p                                                                                               | age 14                                                                                                                                                                      | , "                                                           | 1379                                 | Cross reference Wl                                                              | 49                               | 6/3/08                   |  |
|                          | Based on record rensure the Depart Facilities Division followed by written unusual incidents                   | t met as evidenced beview, the GHMRP fament of Health, Healthwas immediately noting that substantially integers, for one of the four results.                               | ailed to<br>th<br>fied,<br>I hours, of<br>rfered with         |                                      |                                                                                 |                                  |                          |  |
|                          | (Resident #1) include The finding include                                                                      | ided in the sample.                                                                                                                                                         | -                                                             |                                      |                                                                                 |                                  |                          |  |
|                          | 2008, beginning a involving Resident According to the roobserved to be no transferred via am room. Further rev | ity's incident reports to 10:23 AM revealed in the 10:23 AM revealed in the 10:23 AM revealed in the 10:23 AM responsive and was bulance to the emergiew of the incident re | an incident<br>27, 2008.<br>as<br>s<br>gency<br>port          |                                      |                                                                                 |                                  |                          |  |
|                          | Health about the a<br>February 29, 2008<br>At the time of the<br>ensure the Depart<br>#1's incident imme       | IRP notified the Depa<br>forementioned incide<br>(two days after the t<br>survey, the GHMRP t<br>ment of Health was r<br>ediately and followed<br>24 hours as required      | ent on<br>ncident).<br>failed to<br>notified of<br>by written |                                      |                                                                                 |                                  |                          |  |
| I 401                    | 3520.3 PROFESS<br>PROVISIONS                                                                                   | ION SERVICES: GE                                                                                                                                                            | NERAL                                                         | 1401                                 |                                                                                 |                                  |                          |  |
|                          | and evaluation, in<br>developmental lev<br>services, and serv                                                  | ces shall include both<br>cluding identification<br>rels and needs, treatr<br>rices designed to pre<br>rther loss of function                                               | of<br>ment<br>vent                                            |                                      |                                                                                 |                                  |                          |  |
| ····                     | Based on interview GHMRP failed to                                                                             | t met as evidenced by and record review, ensure general and                                                                                                                 |                                                               |                                      |                                                                                 |                                  | ,                        |  |
| Health Regul             | ation Administration<br>M                                                                                      |                                                                                                                                                                             |                                                               | 6899                                 | QX2011                                                                          | If continua                      | tion sheet 15 of 2:      |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDIN                                                                                                                                                            | PLE CONSTRUCTION  G            | (X3) DATE SU<br>COMPLE                                                                                                                             |                                             |                          |
|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------|
|                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                       | B. WING _                      |                                                                                                                                                    | 04/04                                       | 1/2008                   |
| NAME OF P                                                                                  | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADD                                                                                                                                                            | ADDRESS, CITY, STATE, ZIP CODE |                                                                                                                                                    |                                             |                          |
| CMS,                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                       | ERMARLE :<br>TON, DC 2         | STREET NW<br>0008                                                                                                                                  | · .                                         |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                   | (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | FULL                                                                                                                                                                  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)                                                        | SHOULD BE                                   | (X5)<br>COMPLETE<br>DATE |
| l 401                                                                                      | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ige 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                       | I 401                          |                                                                                                                                                    |                                             |                          |
| . !                                                                                        | preventative care s<br>residents (Residen<br>sample.  The finding include                                                                                                                                                                                                                                                                                                                                                                                                                          | ervices, for two of th<br>t #2 and #4) included<br>s.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | e four<br>I in the                                                                                                                                                    | ·                              |                                                                                                                                                    | ,                                           |                          |
|                                                                                            | 1. Observation of Client #4 at the residential facility on April 2, 2008, at 5:14 PM revealed the client was sucking his thumb. Closer observation revealed the client's fingernails were missing on both of his thumbs. The exposed area on each thumb appeared to be discolored (brownish pink). Interview with the former House Manager (HM) at 6:42 PM revealed that the client had an infection on both thumbs that would not heal because of the client's continuous thumb sucking behavior. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                       |                                | l. The facility's psy<br>will clarify, revise,<br>Client #4's BSP of SI<br>thumbsucking. An inse<br>be held on 5/23/08 to<br>employees on the revi | and expand B to includ rvice will train the |                          |
|                                                                                            | Additionally, the for client thumbs were Review of Client #2008 at 5:17 revea dermatologist on Judermatological condiagnosed with chrithumbs that was so and behavioral nail prescribed Triamci on the client's thun Additionally, the de Castellani Paint to the client from suc review of the considermatologist documents.                                                                                                                                                                      | mer HM revealed the being treated for an being treated for an led the client was selly 17, 2007. According to the conference of the condary to his thum I trauma. The derman led the comment of the condary to the comment of the comment of the condary to the conda | at the infection.  April 4, en by the ding to the lient was cting both ab sucking atologist e applied ree weeks. ended y to deterintinued d that the stellaningals as |                                |                                                                                                                                                    |                                             |                          |
| Jealth D                                                                                   | taste of the Castel sucking and be the properties." It sho the nurse verified to                                                                                                                                                                                                                                                                                                                                                                                                                   | sed by a behavior. Idani Paint will deter the appendic due to antifuld be noted that interthet Client #4's thum dhis nails would not                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | numb<br>fungal<br>erview with<br>b sucking                                                                                                                            |                                |                                                                                                                                                    |                                             |                          |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                           | (X2) MULT<br>A. BUILDIN                             | IPLE CONSTRUCTION    | (X3) DATE SU<br>COMPLE                                                                        |             |                          |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------|-----------------------------------------------------------------------------------------------|-------------|--------------------------|
| •                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 09G037                                                                                                                                                                    |                                                     | B. WING_             |                                                                                               | 04/0        | 4/2008                   |
| NAME OF P                                                                                        | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                           | STREET ADI                                          | DRESS, CITY,         | STATE, ZIP CODE                                                                               |             |                          |
| CMS                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ,                                                                                                                                                                         |                                                     | ERMARLE<br>TON, DC 2 | STREET NW<br>20008                                                                            |             |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                         | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SCIDENTIFYING INFORM                                                                                                      | FULL                                                | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE   | (X5)<br>COMPLETE<br>DATE |
| I 401                                                                                            | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ge 16                                                                                                                                                                     | -                                                   | I 401                |                                                                                               |             |                          |
|                                                                                                  | survey, the facility f<br>services were being<br>Client #4's thumbs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ceased. At the time alled to provide evid g provided to effective the table.                                                                                              | ence that<br>ely treat                              |                      | 2. Cross reference W32                                                                        |             | 5/15/08                  |
|                                                                                                  | 2. Review of Client #2's record on April 4, 200 at 7:04 PM revealed the client was seen by an audiologist. Review of the consultation form revealed the client was recommended to return after his ears were cleared. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 7:10 Pl to ascertain if the client had returned for the audiological revisit and/or find out if the revisit was scheduled. At the time of the survey, the facility failed to provide evidence that Client #2 was seen for a follow up audiological visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                     |                      |                                                                                               |             | -                        |
|                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                           |                                                     |                      |                                                                                               |             | ,                        |
|                                                                                                  | (See also Federal I<br>W322)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Deficiency Report Ci                                                                                                                                                      | tation                                              |                      |                                                                                               |             |                          |
|                                                                                                  | Orders on April 3, 3 orders that docume laboratory tests income and a Liver Function Interview with the received and continue failed to provide every street that the received the received that the received the received the received that the received the received the received that the received the received that the received that the received the received the received that the received that the received the received that the received the received the received that the received the received the received that the received t | commended tests v                                                                                                                                                         | ealed ive 7 3 months 6 month. on April 4, 's record |                      | 3a±Cross reference W3                                                                         | 25 #1       | 4/24/08                  |
| Health Requ                                                                                      | at 2:19 PM revealed<br>October 23, 2007.<br>urinalysis results rephysician signed the<br>indicating a urine of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | at #1's record on Apred the client had a un<br>Further review of the<br>evealed the primary<br>he test and wrote a roulture and sensitivity<br>interview was conductions. | inalysis on<br>ne<br>care<br>note<br>y test         |                      | 3b. Cross reference W                                                                         | 325 #2      | 5/16/08                  |
| STATE FOR                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                           |                                                     | 6899                 | QX2011                                                                                        | If continua | tion sheet 17 of 2       |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NO 09G037 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      | MBER:                                                                                      | A BUILDING<br>B. WING |                                                                                 | (X3) DATE SU<br>COMPLE<br>04/04   |                          |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------|-----------------------------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER ST                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      |                                                                                            |                       | TATE, ZIP CODE                                                                  |                                   |                          |
| CMS                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      | WASHING                                                                                    | ERMARLE S             | 0008                                                                            |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG                                                                       | (EVCH DEEICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM                                                                                                                                                                                             | ( FULL                                                                                     | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| I 401                                                                                          | (QMRP) on April 4 culture and sensitir the time of the surevidence that the unad been complete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | al Retardation Profes<br>, 2008 to ascertain if<br>vity had been comple<br>vey, the facility failed<br>urine culture and sen                                                                                                                                         | the urine ated. At to provide asitivity test                                               | I 401                 |                                                                                 |                                   |                          |
| I 422                                                                                          | Each GHMRP sha<br>and assistance to<br>the resident 's Ind<br>This Statute is no<br>Based on observa<br>review, the GHMP<br>training and assis<br>residents in accor<br>Habilitation Plan(s                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | FION AND TRAINING all provide habilitation residents in accordatividual Habilitation F at met as evidenced bettien interview and ref RP failed to ensure hat tance was provided to dance with their Indi s), for one of the four uded in the sample.                 | n, training<br>ance with<br>Plan.<br>by:<br>ecord<br>abilitation,<br>to its                | 1 422                 |                                                                                 |                                   |                          |
|                                                                                                | The finding included During the entrant at approximately former House Matter House | ce conference on Ap<br>9:40 AM, interview wanager (HM) revealed<br>upervision for eight (<br>r HM further revealed:<br>1 staffing supports of<br>The special staffing<br>to assist Client #3 value behaviors of<br>telf injurious behaviors<br>lient #3 on the eveni | with the dithat Client (8) hours dithat Client only while a group ort with elopement, ors. | t<br>t                |                                                                                 |                                   |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G037 |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                     |                                                                                                             | (X2) MULTI<br>A. BUILDIN<br>B. WING _ | PLE CONSTRUCTION G                                                                                  | (X3) DATE SU<br>COMPLE |                  |
|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------|------------------|
|                                                                                                             |                                                                                                                                                                                                            | 09G037                                                                                                                                                                                                                                                              | STREET ADD                                                                                                  | RESS CITY S                           | STATE, ZIP CODE                                                                                     |                        |                  |
| C M S                                                                                                       | ROVIDER OR SUPPLIER                                                                                                                                                                                        |                                                                                                                                                                                                                                                                     | 3815 ALBE                                                                                                   |                                       | STREET NW<br>0008                                                                                   |                        | <u>.</u>         |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (FACH DEFICIENC)                                                                                                                                                                                           | TEMENT OF DEFICIENCIE<br>MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM                                                                                                                                                                                               | FULL                                                                                                        | ID<br>PREFIX<br>TAG                   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SE<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE               | COMPLETE<br>DATE |
| 1 422                                                                                                       | Continued From pa                                                                                                                                                                                          | ige 18                                                                                                                                                                                                                                                              |                                                                                                             | 1 422                                 |                                                                                                     |                        |                  |
|                                                                                                             | the aforementioned<br>was not observed t<br>residential facility b                                                                                                                                         | 11:56 AM-12:14 PM<br>I staffing supports. (<br>to have a 1:1 staff wh<br>out was observed to h<br>:1 staff person while                                                                                                                                             | Client #3<br>nile in the<br>nave the                                                                        |                                       |                                                                                                     |                        |                  |
|                                                                                                             | on April 3, 2008 at information regard According to the in that he/she provide Monday through Fithat Client #3 had aggression and ha                                                                       | lucted with Client #3' 12:08 PM to ascertaing the 1:1's responsterview, the 1:1 staffed 1:1 support for Cliriday. The 1:1 furthe behaviors of elopeming 1:1 supports asing those behaviors.                                                                         | in<br>sibilities.<br>revealed<br>ent #3<br>er indicated<br>ent and<br>sisted the                            |                                       |                                                                                                     |                        |                  |
|                                                                                                             | Professional (QMF records on April 4, client had a Behav November 26, 200 Client #3 had chall non-compliance, positting, hoarding.                                                                         | Qualified Mental Reta<br>RP) and review of Cli<br>2008 at 12:39 PM re-<br>ior Support Plan (BS<br>7. The plan docume<br>lenging behaviors of<br>hysical aggression, of<br>masturbation, repetion                                                                    | ent #3's evealed the SP) dated ented that eloping, tive                                                     | ÷                                     |                                                                                                     |                        |                  |
|                                                                                                             | entitled, "Need for section, the plan of primarily a danger without a 1:1 staff psychiatric Axis I: his behaviors are weekends, upstair anywhere at anytimay at any mome he may grab anot dangerous extent | of the plan revealed 1:1 Staffing." According to himself and/or other person at all times. Impulse Control Discunpredictable day, now, downstairs, on the me. For example, [Ont suddenly attempting person sexually the may embarrass but sexually or inappression. | rding to that ent #3 is hers He has a order and ight, e van and Client #3] to elope or To a less nimself or |                                       |                                                                                                     |                        |                  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | A. BUILDIN          | PLE CONSTRUCTION                                                                                     | (X3) DATE SURVEY<br>COMPLETED |               |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------|-------------------------------|---------------|
|                                                                                                     |                                                                                                                                                                                                                                 | 09G037                                                                                                                                                                                                                                                                                                  |                                                                                | B. WNG_             |                                                                                                      | 04/04                         | /2008         |
| NAME OF P                                                                                           |                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | RESS, CITY, S       |                                                                                                      |                               |               |
| CMS                                                                                                 |                                                                                                                                                                                                                                 | ·<br>                                                                                                                                                                                                                                                                                                   |                                                                                | TON, DC 2           |                                                                                                      | ·                             | · .           |
| (X4) ID<br>PREFIX<br>TAG                                                                            | (FACH DEFICIENC)                                                                                                                                                                                                                | TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORM                                                                                                                                                                                                                                       | FULL                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | COMPLETE DATE |
| 1 422                                                                                               | Continued From pa                                                                                                                                                                                                               | nge 19                                                                                                                                                                                                                                                                                                  |                                                                                | 1 422               |                                                                                                      |                               |               |
|                                                                                                     | behaviors around of<br>etc [Client #3] do<br>staff person is next<br>him." The plan fund<br>"[Client #3] is also<br>not properly redired<br>1:1, as he may be<br>times. It should be<br>information was for<br>November 26, 200 | 1:1 staff person moni-<br>others, in front of wind<br>es much better wher<br>to him, immediately<br>ther documented that<br>a danger to others we<br>cted by someone suc<br>more aggressive at the<br>enoted that the afore-<br>und not only in the B<br>7 but also in Client #<br>ted February 21, 200 | dows, n a familiar next to t the hen he is ch as a hese mentioned SP dated 3's |                     |                                                                                                      |                               |               |
|                                                                                                     | Review of the correlative of the month revealed the follow frequency of Client behaviors of elope                                                                                                                               | esponding data sheens of April 2007 and ving information regated t#3's exhibited challed ment, inappropriately hair and aggression.                                                                                                                                                                     | ets<br>June 2007<br>rding the<br>enging<br>y touching                          |                     |                                                                                                      |                               |               |
|                                                                                                     | incidents of pulling<br>May 2007 - 3 incident<br>others, 73 incident<br>of aggression.<br>June 2007 - 1 incident                                                                                                                | lents of elopement, 3<br>ts of pulling his hair,<br>dent of elopement, 1<br>, 70 incidents of pulli                                                                                                                                                                                                     | touching<br>7 incidents<br>1 incidents                                         |                     |                                                                                                      |                               |               |
|                                                                                                     | Review forms on A                                                                                                                                                                                                               | lity Psychotropic Med<br>April 3, 2008 at 5:3<br>t engaged in incident<br>hallenging behaviors                                                                                                                                                                                                          | 1 PM<br>ts of the                                                              |                     |                                                                                                      |                               |               |
|                                                                                                     | behavior, 1 incide                                                                                                                                                                                                              | lent of elopement rel<br>nt of touching others<br>g his hair, and 8 incid                                                                                                                                                                                                                               | , 158                                                                          | , · · ·             |                                                                                                      | ·                             |               |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                              |                                                          | (X2) MULTI<br>A. BUILDIN<br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PLE CONSTRUCTION G                                                                  | COMPLE                   | (X3) DATE SURVEY<br>COMPLETED                 |  |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------|-----------------------------------------------|--|
|                                                     |                                                                                                                                                                                                                                                                                   | 09G037                                                                                                                                                                                             |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     | 04/0-                    | 4/2008                                        |  |
|                                                     |                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                    |                                                          | STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | -                                                                                   |                          |                                               |  |
| C M S 3815 ALBI<br>WASHING                          |                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                    | TON, DC 2                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                          |                                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                            |                                                                                                                                                                                                    |                                                          | ID<br>PREFIX<br>TAG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | (X5)<br>COMPLETE<br>DATE |                                               |  |
| 1 422                                               | Continued From page 20                                                                                                                                                                                                                                                            |                                                                                                                                                                                                    |                                                          | 1422                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                     |                          |                                               |  |
|                                                     | aggression.  August 2007 - 1 incident of touching others, 69 incidents of pulling his hair, and 11 incidents of aggression.  September 2007 -2 incidents of elopement behavior, 4 incidents of touching others, 185 incidents of pulling his hair, and 7 incidents of aggression. |                                                                                                                                                                                                    |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Cross reference W24                                                                 | 9                        | 5/14/08                                       |  |
| #                                                   | records revealed the in the aforemention through March 200 the facility failed to with continuous ac needed supports to behaviors.                                                                                                                                                | that review of the client continued to the client continued to the challenging behalls. At the time of the ensure Client #3 was tive treatment including address his challent Deficiency Report Ci | engage<br>aviors<br>survey,<br>s provided<br>ing<br>ging |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                          |                                               |  |
| 1 500                                               | that the rights of re<br>protected in accord                                                                                                                                                                                                                                      | r'S RIGHTS idence director shall esidents are observed dance with D.C. Law applicable District ar                                                                                                  | d and<br>2-137, this                                     | 1 500                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Cross reference W10<br>#1, W249, W262                                               | 4, W124, W120            | 5/23/08                                       |  |
|                                                     | Based on observa<br>review, the GHMR<br>protections of each<br>The findings include<br>(See Federal Defin                                                                                                                                                                         | -                                                                                                                                                                                                  | ecord<br>e                                               | sea - i disperimentale del construcción de la const |                                                                                     |                          |                                               |  |
|                                                     | V4 122, VV 124, VV2                                                                                                                                                                                                                                                               | 73, VVZUZ, VVZUS)                                                                                                                                                                                  |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                     |                          | <u>,                                     </u> |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                    |                                    | A. BUILDIN                           | PLE CONSTRUCTION                                                                                                | (X3) DATE SUR\<br>COMPLETE |                                       |  |
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| 09G037                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                    |                                    | B. WING 04/0                         |                                                                                                                 | 04/04                      | 1/2008                                |  |
| NAME OF PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADD                         | DRESS, CITY, STATE, ZIP CODE         |                                                                                                                 |                            |                                       |  |
| CMS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                    |                                    | SERMARLE STREET NW<br>STON, DC 20008 |                                                                                                                 |                            |                                       |  |
| PREFIX (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                       |                                    |                                      | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY)                         | THE APPROPRIATE            |                                       |  |
| R 000 INITIAL COMMENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                      |                                                                                                                 | ;                          |                                       |  |
| from April 2, 2008 random sample of from a residential period mental retardation a survey findings went the group home and interviews and a rev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | An annual relicensure survey was conducted from April 2, 2008 through April 4 2008. A random sample of four residents was selected from a residential population of seven males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at four day programs, interviews and a review of records, including unusual incident reports. |                                    |                                      |                                                                                                                 |                            |                                       |  |
| R 122 4701.2 BACKGROU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | JND CHECK REQU                                                                                                                                                                                                                                                                                                                                                                                     | IREMENT                            | R 122                                |                                                                                                                 |                            | ·                                     |  |
| facility shall obtain a<br>and shall either obtain<br>District of Columbia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | in section 4701.6, ea<br>a criminal backgroun<br>ain or conduct a che<br>i Nurse Aide Abuse I<br>r using the contract s<br>rson.                                                                                                                                                                                                                                                                   | d check,<br>ck of the<br>Registry, |                                      |                                                                                                                 |                            |                                       |  |
| Based on interview<br>GHMRP failed to er<br>checks had been of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | met as evidenced by<br>and the review of re<br>asure criminal backg<br>stained before emplo<br>ervices of an unlicer                                                                                                                                                                                                                                                                               | cords, the round oring or          |                                      |                                                                                                                 |                            |                                       |  |
| The finding includes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | s:                                                                                                                                                                                                                                                                                                                                                                                                 |                                    | •                                    |                                                                                                                 |                            |                                       |  |
| and review of the person of th | ormer House Managersonnel records on evealed that the GHI dence that a criminal had been obtained g the services of the                                                                                                                                                                                                                                                                            | April 2,<br>MRP<br>Il<br>prior to  |                                      | CMS Personnel Dept. wil all records to ensure temployees have criminal ground checks prior to in this facility. | hatdall<br>back-           | 5/23/08                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                    |                                    |                                      |                                                                                                                 |                            |                                       |  |
| lealth Regulation Administration  ABORATORY DIRECTOR'S OR PROVID  ATATE FORM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | EKISUPPLIER REPRESEN                                                                                                                                                                                                                                                                                                                                                                               | FATIVE'S SIGN                      |                                      | ro ram Duesta                                                                                                   | ) 5                        | (X6) DATE  - 9 - 0  tion sheet 1 of 1 |  |